

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03297

Reg. Dist. No. 302

Dr. Ditto

3373

CERTIFICATE OF DEATH

1. PLACE OF DEATH

o. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Hagerstown R#4

c. LENGTH OF STAY IN 1b

39 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

m Cearfoss

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown R#4

d. STREET ADDRESS

Cearfoss

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First MARY

Middle ALICE

ANGLE

Last

4. DATE
OF
DEATH

Month March

Day 26,

Year 19 56

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

July 21, 1884

9. AGE (In years
from last birthday)

71

yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Broadfording, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Spickler

14. MOTHER'S MAIDEN NAME

Aranda Sword

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

No

- - - - -

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mr. A. Clifford Angle-Hagers, R#4

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Atrial fibrillation Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH
2 yrs

4/20/50

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 12-1-1955 to March 26, 1956, that I last saw the deceased alive on March 26, 1956, and that death occurred at 9:30 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

3-29-56

22c. NAME OF CEMETERY OR CREMATORIUM

Dunkard Cemetery

22d. LOCATION (City, town, or county)

Broadfording, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Andrew K. Coffman-Hagerstown, Maryland

24a. REC'D BY REGISTRAR

Mar. 30, 1956

24b. REGISTRAR'S SIGNATURE

H. H. Bowes

BUREAU V. 2

APR 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3374

CERTIFICATE OF DEATH

03298

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	c. LENGTH OF STAY IN 1b 2 MONTHS	b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. STREET ADDRESS 5131 FIRST ST. IV. W.					
3. NAME OF DECEASED (Type or print) ELLIS - ERBAUGH.	First	Middle	Last		
4. DATE OF DEATH MARCH - 26 - 1956	Month	Day	Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. - 4 - 1887		
9. AGE (In years lost birthday) 68-622	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - U.S. DEPT. OF AGRICULTURE	10b. KIND OF BUSINESS OR INDUSTRY PRINCE GEORGES CO. MD. U.S.A.	11. BIRTHPLACE (State or foreign country) PRINCE GEORGES CO. MD. U.S.A.	12. CITIZEN OF WHAT COUNTRY? HOA MAGNOLIA AVE Address		
13. FATHER'S NAME GEOFFREY BARBER	14. MOTHER'S MAIDEN NAME JEANETTE GARNAHAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT MRS. ETHEL M. JACKSON	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		
			INTERVAL BETWEEN ONSET AND DEATH 3 days		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat. white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore, Md.	20f. (City or town) Washington D.C.	(County)	(State)
21. I certify that I attended the deceased from March 23, 1956 to March 26, 1956 , that I last saw the deceased alive on March 26, 1956 , and that death occurred at 7 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE J.W. LeBaron M.D. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-29-1956	22c. NAME OF CEMETERY OR CREMATORIUM ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) WASHINGTON D.C.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE FRANK J. JOY -	ADDRESS WASHINGTON D.C.	24a. REC'D BY REGISTRAR John H. Bush	24b. REGISTRAR'S SIGNATURE		
DATE MAR. 27-1956					

CERTIFICATE OF DEATH

Date of Birth

MARCH 30 1956

FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

3322

CERTIFICATE OF DEATH

Dr Lusby

03299
305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 28 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1127 Hamilton Blvd		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1127 Hamilton Blvd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EDNA		First MYRTLE	Middle BELL	4. DATE OF DEATH March 23 1956	Month March	Day 23	Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 1 1889	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) near Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward L. Needy		14. MOTHER'S MAIDEN NAME Alice Kiracofe						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George F. Bell Hagerstown Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma rt. breast with generalized Metastasis						INTERVAL BETWEEN ONSET AND DEATH 2 yrs +		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO DUE TO DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1 Mar , 19 55 , to 23 Mar , 19 56 , that I last saw the deceased alive on 23 Mar , 19 56 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE F.F. Lusby PHYSICIAN'S NAME (Type) F.F. Lusby								ADDRESS (Street, city or town, state) 230 N Potomac
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Mar 26 1956		24b. REGISTRAR'S SIGNATURE Frank Bowers		

WILSON COUNTY STATE DEPARTMENT OF HUMAN SERVICES		CERTIFICATE OF DEATH	
DECEASED PERSON'S NAME JAMES LEE COOPER		DATE OF DEATH MARCH 28, 1956	
ADDRESS 1234 FAIRFIELD DR.		CITY KNOXVILLE	
COUNTY WILSON		STATE TENNESSEE	
AGE 65		SEX MALE	
RACE WHITE		CAUSE OF DEATH HEART DISEASE	
MATERIAL TESTED BLOOD		TESTS MADE Hemoglobin	
TEST RESULTS Normal		TESTER Dr. J. W. COOPER	
TESTER'S SIGNATURE <i>J. W. Cooper</i>		TESTER'S TITLE Physician	
TESTER'S ADDRESS 1234 FAIRFIELD DR.		TESTER'S CITY KNOXVILLE	
TESTER'S COUNTY WILSON		TESTER'S STATE TENNESSEE	
TESTER'S PHONE 555-1234		TESTER'S SIGNATURE <i>J. W. Cooper</i>	
RECEIVED BUREAU N.Y.C. MAR 28 1956			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, FilmG195 4-6-56 et

13300
304

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock		c. LENGTH OF STAY IN 1b Home				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bridget		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Bridget R. Bishop		4. DATE OF DEATH 3 24 1956	Month Day Year			
S. SEX F	6. COLOR OR RACE W WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2. 1875			
9. AGE (In years (last birthday) yrs. 80		10. IF UNDER 1 YEAR Months 4 Days 18	11. IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife				
11. BIRTHPLACE (State or foreign country) Washington County Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Jacob Pryor		14. MOTHER'S MAIDEN NAME Mary Terry				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs Katie Sciece R.F.D.1 Hancock Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Chronic Myocarditis arterio sclerosis 2 mo				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10 p. m. 10		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work 10	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4A	20f. (City or town) Hancock Md	(County) Hancock Co	(State) Md
21. I certify that I attended the deceased from Jan 20, 1956 , to Mar 24, 1956 that I last saw the deceased alive on dead Mar 24, 1956 , and that death occurred at 4A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hancock Md		DATE SIGNED 3/25/56		
ACTUAL SIGNATURE L.M. Shaffer		PHYSICIAN'S NAME (Type) L.M. Shaffer				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3.26.56	22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery	22d. LOCATION (City, town, or county) Near Hancock Washington Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Honored & Steve Hancock Md		ADDRESS 100 Main St Hancock Md		24a. REC'D BY REGISTRAR Jul 16	24b. REGISTRAR'S SIGNATURE J.W. Neller	

DEPARTMENT OF HEALTH - CALIFORNIA

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3323

CERTIFICATE OF DEATH

Dr Lusby

03301
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 35 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 45 Fairground Ave			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 45 Fairground Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EMMA		First	Middle	Last	4. DATE OF DEATH BRENNER	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9 1873		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cavetown Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George W. Noel		14. MOTHER'S MAIDEN NAME Helen Justice							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Robt Thornburg Hagerstown Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arterio Sclerotic Heart Disease with myocardial Failure				INTERVAL BETWEEN ONSET AND DEATH 10 yr +			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO							
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inj							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 230 N Potomac St		20f. (City or town) Hagers Town Md		(County)	(State)
21. I certify that I attended the deceased from Jan , 1945, to 31 Mar , 1956, that I last saw the deceased alive on 28 Mar , 1956, and that death occurred at 6:00 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) M.D. 230 N Potomac St		DATE SIGNED	
ACTUAL SIGNATURE F.F. Lusby									
PHYSICIAN'S NAME (Type) F.F. Lusby									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/56		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Apr. 2, 1956		24b. REGISTRAR'S SIGNATURE John H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH-AG-1140-A
CENTRAL STATE OF DEATH 8208

BUREAU V. S.

APR 4 1956

REGGIE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03.302

3324

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 yrs. 9 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 119 E. 3 rd. Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MATTIE	Middle MAY	Last BUESING	4. DATE OF DEATH	Month March	Day 25	Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 9, 1874	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Days 16	Hours 4	Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lewistown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Wiles			14. MOTHER'S MAIDEN NAME Mary E. Wiles					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Rev. Mark G. Wagner		Address Hagerstown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Cause of Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH 48 hrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p.m.	Month 19	Day	20d. INJURY OCCURRED White ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Frederick	(State) Maryland	
21. I certify that I attended the deceased from 3-27 , 19 56 , to 3-25 , 19 56 , that I last saw the deceased alive on 3-20-56 , 19 56 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. FW. Dill Jr.</i> ADDRESS (Street, city or town, state) <i>Hagerstown Md.</i> DATE SIGNED <i>1956</i> PHYSICIAN'S NAME (Type) <i>J. FW. Dill Jr.</i> M.D. <i>Hagerstown Md.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/28/1956	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick Maryland (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Family Funeral Home Charles M. Longen</i>				ADDRESS Hagerstown, Maryland	24a. REC'D BY REGISTRAR Mar. 27, 1956	24b. REGISTRAR'S SIGNATURE <i>Chas. H. Powers</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 29 1956

REFUGEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03.03

3325

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 2 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. RFD #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Hagerstown Md. RFD #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Catherine	Middle Ann	Last Carbaugh	4. DATE OF DEATH Month March	Month 25	Day 1956	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23 1956	9. AGE (In years lost birthday) yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilbur F. Carbaugh		14. MOTHER'S MAIDEN NAME Betty Mc Bride					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Wilbur Carbaugh		Address Hagerstown Md. RFD#1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Premature Birth DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH 7mo. Gestation Twin 2 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 23, 1956 , to Mar 25, 1956 , that I last saw the deceased alive on Mar 24, 1956 , and that death occurred at 3:25A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer		M.D.		ADDRESS (Street, city or town, state) Clear Spring Md.		DATE SIGNED 3/26/56	
PHYSICIAN'S NAME (Type) David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 27-56		22c. NAME OF CEMETERY OR CREMATORIAL Church Of God Cemetery		22d. LOCATION (City, town, or county) Blairs Valley (State) Clearspring Md. RFD	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport Md		ADDRESS 208127730V		24a. REC'D BY REGISTRAR Mer. 27 1956		24b. REGISTRAR'S SIGNATURE Albert Leaf Williamsport Md	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK - VOLUME 18
CERTIFICATE OF DEATH

DECEASED PERSON'S NAME: MARY ANN HARRIS

2

DECEASED PERSON'S ADDRESS: 123 FAIRFIELD AVENUE, NEW YORK CITY

NAME AND ADDRESS OF DOCTOR: DR. JAMES M. SMITH, 123 FAIRFIELD AVENUE, NEW YORK CITY

NAME AND ADDRESS OF FUNERAL DIRECTOR: FREDERIC W. SMITH, 123 FAIRFIELD AVENUE, NEW YORK CITY

NAME AND ADDRESS OF CEMETERY: NEW YORK CITY CEMETERY, 123 FAIRFIELD AVENUE, NEW YORK CITY

BUREAU V.

MAR 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH										Reg. Dist. No. 03304 302				
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. RFD #1									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital					d. STREET ADDRESS Hagerstown Md. RFD #1					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Mary	Middle Ann	Carbaugh	4. DATE OF DEATH March 24	Month March	Day 24	Year 1956						
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 23 1956	9. AGE (In years lost birthday) yrs. 1 yrs.	IF UNDER 1 YEAR Months 1		IF UNDER 24 HRS. Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown Md.			12. CITIZEN OF WHAT COUNTRY/ USA					
13. FATHER'S NAME Wilbur F. Carbaugh				14. MOTHER'S MAIDEN NAME Betty Mc Bride										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Wilbur Carbaugh		Address Hagerstown Md. RFD #1								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Premature Birth</i> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>7mo. Gestation Twin</i> DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>17 hours.</i>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Clear Spring Md.		(County)		(State)					
21. I certify that I attended the deceased from Mar 23, 1956, to Mar 24, 1956, that I last saw the deceased alive on Mar 24, 1956, and that death occurred at 9:10A M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Clear Spring Md. 36656				
ACTUAL SIGNATURE <i>David R Brewer</i> M.D.										DATE SIGNED Mar 27 1956				
PHYSICIAN'S NAME (Type) David R. Brewer		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial								22b. DATE THEREOF March 27-56	22c. NAME OF CEMETERY OR CREMATORIUM Blair's Valley Church of God Cemetery	22d. LOCATION (City, town, or county) Clearspring Md. RFD #1		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert A. Leaf Williamsport Md</i>		ADDRESS 3001 27th St. Williamsport Md								24a. REC'D BY REGISTRAR Mar 27 1956	24b. REGISTRAR'S SIGNATURE <i>Wm. H. Bowers</i>			

EF 380012A-0714-B-00 TRANSACTIONS STARTED 0714

BUREAU V.

MAR 29 1956

REGIYED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3376

CERTIFICATE OF DEATH

03305
305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland				
<input checked="" type="checkbox"/> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairplay Md.		c. LENGTH OF STAY IN 1b 10 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairplay Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Samuel		First S.	Middle Cattlett			
4. DATE OF DEATH March 14	Month March	Day 14	Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27 1872			
9. AGE (In years less birthday) 83 yrs.	10. IF UNDER 1 YEAR 11 months	11. IF UNDER 24 HRS. 8 hours	12. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Berkeley Co. W. Va.			
13. FATHER'S NAME Samuel W. Cattlett		14. MOTHER'S MAIDEN NAME Ellise Jane Hoile				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Gustave Cattlett			
		Address Fairplay Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Coronary Thrombosis Day				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Williamsport, Md.	20f. (City or town) Williamsport	(County) Lycoming Co.	(State) Penn.
21. I certify that I attended the deceased from 3/13/56 to 3/14/56 , that I last saw the deceased alive on 3/14/56 , and that death occurred on 3/14/56 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Williamsport, Md.		DATE SIGNED 3/14/56		
ACTUAL SIGNATURE Ralph Young		PHYSICIAN'S NAME (Type) William H. East				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 17-56	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) Near Glen Gary W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		ADDRESS Williamsport Md.		24a. REC'D BY REGISTRAR Mar. 15 1956	24b. REGISTRAR'S SIGNATURE John H. East	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

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WILSON COUNTY, STATE OF HAWAII - DEATH CERTIFICATE

CERTIFICATE OF DEATH

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BUREAU V. S.

MAR 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3327

CERTIFICATE OF DEATH

03306
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 32 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 317 N. Locust St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. STREET ADDRESS 317 N. Locust		d. STREET ADDRESS 317 N. Locust	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First David Middle Henry Last Crumbacker		4. DATE OF DEATH Month March Day 16 Year 1956	
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH May 25, 1880		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (State or foreign country) Unionbridge Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel J. Crumbacker		14. MOTHER'S MAIDEN NAME Annie B. Greenwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-2780 17. INFORMANT D. Marshall Crumbacker Westminister Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Carcinomatosis INTERVAL BETWEEN ONSET AND DEATH 2 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Primary in Prostate Gland. ?			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 4, 1956, to March 14, 1956, that I last saw the deceased alive on March 14, 1956, and that death occurred at 3:00A.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. A. Bell, ADDRESS (Street, city or town, state) Hagerstown, Maryland DATE SIGNED Mar. 17, 1956.			
PHYSICIAN'S NAME (Type)		119 North Potomac Street,	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18-56 22c. NAME OF CEMETERY OR CREMATORIUM Pipe Creek Cemetery 22d. LOCATION (City, town, or county) Near Uniontown Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hag. Md.		ADDRESS 24a. REC'D BY REGISTRAR Mar. 20, 1956 24b. REGISTRAR'S SIGNATURE Chester D. Danner	

8

STATE DEPARTMENT OF HEALTH - SANITATION

STATE OF DELAWARE

BUREAU Y. S.

MAR 22 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Graff

3328

CERTIFICATE OF DEATH

03307

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 200 Beuna Vista Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) DAVID		First WAYNE	Middle DAVIS	Last DAVIS	4. DATE OF DEATH March 7, 1956	Month March	Day 7	Year 1956
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 29, 1956	9. AGE (In years lost birthday) yrs. 0	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Bennie Davis		14. MOTHER'S MAIDEN NAME Sarah Dawson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sylvia Davis		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory failure				INTERVAL BETWEEN ONSET AND DEATH minutes		
776X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		(b) DUE TO Prematurity	seven months of gest.			7 months		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 119 E. Antietam St.	(County) (State)	
21. I certify that I attended the deceased from 2-29-56 , 19, to 3-7-56 , 19, that I last saw the deceased alive on 5-6-56 , 19, and that death occurred at 430 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Hagerstown		
ACTUAL SIGNATURE <i>Louis G. Graff</i>						DATE SIGNED 3-7-56		
PHYSICIAN'S NAME (Type) Louis G. Graff, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-56		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Bloomington-Garrett Co.		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Mar. 9, 1956		24b. REGISTRAR'S SIGNATURE <i>Joseph Bowers</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

2023 RELEASE UNDER E.O. 14176

BUREAU V. S.

MAR 12 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03308

3329

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania		b. COUNTY Bedford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 yrs. 6 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bedford		d. STREET ADDRESS unknown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JENNIE		First	Middle	Lost	4. DATE OF DEATH DIEHL	Month March	Day 25	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 26, 1870	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 29	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bedford County, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Job Diehl				14. MOTHER'S MAIDEN NAME Susannah Harderode				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Rev. Mark G. Wagner Hagerstown, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0				<i>Arterio sclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 		DUE TO 						
(c) 		DUE TO 						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County)	(State)
21. I certify that I attended the deceased from 12-1- , 19 56 , to 3-25- , 19 56 , that I last saw the deceased alive on 3-24-56 , 19 56 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED								
ACTUAL SIGNATURE <i>I am Dr. D. W. Settle M.D.</i>								
PHYSICIAN'S NAME (Type) <i>Dr. E. W. Settle Jr.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/27/1956	22c. NAME OF CEMETERY OR CREMATORIUM Bedford Cemetery		22d. LOCATION (City, town, or county) Bedford		(State) Pennsylvania		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles M. Roemer</i>		ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR Mar. 27, 1956	24b. REGISTRAR'S SIGNATURE <i>Charles H. Powers</i>			

BUREAU V. S.

956 | శతాబ్ది

LEGEND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3377

CERTIFICATE OF DEATH

03309

Reg. Dist. No.

306

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Smithsburg		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <input checked="" type="checkbox"/> S. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Martin	Middle Thomas	Last Eckstine
4. DATE OF DEATH	Month March	Day 12	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1877
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input checked="" type="checkbox"/> supervisor			
10b. KIND OF BUSINESS OR INDUSTRY County roads Dpt. Chewsville, Md.			
11. BIRTHPLACE (State or foreign country) Chewsville, Md.			
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George Eckstine		14. MOTHER'S MAIDEN NAME Molly Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-05-6671 17. INFORMANT Lester Eckstine, Smithsburg, Md.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO 527.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Pulmonary Emphysema DUE TO (c) Old Myocardial Infarction			
INTERVAL BETWEEN ONSET AND DEATH 2 mos.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/22, 1955, to 3/12, 1956, that I last saw the deceased alive on 3/12, 1956, and that death occurred at 7130A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 3/12/56	
PHYSICIAN'S NAME (Type) Charles F. Hess			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-14-56	
22c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE Mar 13/56		24b. REGISTRAR'S SIGNATURE Geo W F Ferguson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

CERTIFICATE OF DATA

of does not exceed 1000 words.

by John C. Tracy (Signature)

for John C. Tracy (Signature)

on March 14, 1956 (Date)

in Bureau of Investigation (Office)

FEDERAL BUREAU OF INVESTIGATION

MAR 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3378

CERTIFICATE OF DEATH

04470
3041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b 10 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		d. STREET ADDRESS R.F.D. 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Albert	Middle E	Last Eichelberger	4. DATE OF DEATH	Month 3	Day 29	Year 19 56
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1887	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired conductor		10b. KIND OF BUSINESS OR INDUSTRY W.Md. R.R.		11. BIRTHPLACE (State or foreign country) Hancock, Md. R2		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Eichelberger		14. MOTHER'S MAIDEN NAME Charlotte Selby					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.War L		17. INFORMANT Mrs. Lulu Eichelberger		Address Hancock, Md. R2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		Gc. Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH Sudden		Chronic Bronchial Asthma 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 29, 1954 to Mar 29, 1956 that I last saw the deceased alive on Mar 29, 1956 , and that death occurred at 12301 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE DAVID R. BREWER		M.D.		Clear Spring Md 35052			
PHYSICIAN'S NAME (Type) DAVID R. BREWER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS Clearspring, Md.		24a. REC'D BY REGISTRAR DATE 4/2/56		24b. REGISTRAR'S SIGNATURE J. Kelle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
CERTIFICATE OF DEATH

BUREAU V. S.

APR 16 1956

REFUGEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3330

CERTIFICATE OF DEATH

03310
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SMITHSBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 81 WASHINGTON COUNTY				d. STREET ADDRESS Rt #2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle U	4. DATE OF DEATH MARCH 14, 1956	Month Day Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 70 yrs.	
9. AGE (In years lost birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck farmer		10b. KIND OF BUSINESS OR INDUSTRY Truck farmer	
11. BIRTHPLACE (State or foreign country) Edgemont, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY F. FISHACH		14. MOTHER'S MAIDEN NAME CATHERINE MINER		Address William Fishach, Waynesboro Pa.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT William Fishach, Waynesboro Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X		Central Thrombosis 6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Bleeding duodenal ulcer 14 days			
DUE TO (c)		Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 20, 1956 , to March 14, 1956 , that I last saw the deceased alive on March 14, 1956 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 215 W Washington St 31556			
ACTUAL SIGNATURE John A. Moran		DATE SIGNED 3/15/56			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/18/56		22c. NAME OF CEMETERY OR CREMATORIAL LEITERSBURG	
22d. LOCATION (City, town, or county) Leitersburg M.D.					
23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Moore		ADDRESS Waynesboro, Pa.		24a. REC'D BY REGISTRAR DATE Mar 17, 1956	
				24b. REGISTRAR'S SIGNATURE Frank Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 20 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3379 CERTIFICATE OF DEATH

03311
 304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland		d. STREET ADDRESS W Main St.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Aldean Lee Foltz		First	Middle	Last	4. DATE OF DEATH Dec. 21 1923	Month	Day	Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21 1923	9. AGE (In years lost birthday) 32 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3	Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenog.		10b. KIND OF BUSINESS OR INDUSTRY Farm Corp.		11. BIRTHPLACE (State or foreign country) Washington County Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Clarence Foltz				14. MOTHER'S MAIDEN NAME Gertrude E Michael						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-8925		17. INFORMANT Mrs Gertrude E Foltz Hancock Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 170X				Pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)		DUE TO 170X		Carcinoma lungs		15 mo				
(c)		DUE TO 170X		Carcinoma breast						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 170X								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 170X		20f. (City or town) 170X		(County) 170X	(State) 170X	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above.										
ACTUAL SIGNATURE L.M. Shaffer		ADDRESS (Street, city or town, state) Hancock Md 3/24							DATE SIGNED 3/24/56	
PHYSICIAN'S NAME (Type) L.M. Shaffer										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3.25.56		22c. NAME OF CEMETERY OR CREMATORIUM Presbyterian Cemetery		22d. LOCATION (City, town, or county) Hancock Washington Maryland			(State) 170X	
23. FUNERAL DIRECTOR'S SIGNATURE House & Sons 141 W Main Hancock		ADDRESS me							24a. REG'D BY REGISTRAR 3/25/56	24b. REGISTRAR'S SIGNATURE J. Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - ALBIONESE 18
CERTIFICATE OF DEATH

BUREAU V. S.

MAR 9 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03312

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY 03 WASHINGTON	MARYLAND	STATE MARYLAND	COUNTY WASHINGTON		
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HAGERSTOWN	LENGTH OF STAY (in this place) LIFE	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN	STREET ADDRESS (If rural give location) 930 KUHN AVE.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 930 KUHN AVE.					
3. NAME OF DECEASED (First) CUSHEN (Middle) ARTHUR (Last) FORSYTH			4. DATE OF DEATH MARCH 27 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, MARRIED	8. DATE OF BIRTH 7/15/1894	9. AGE last birthday 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY MOVING & STORAGE CO.	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FORSYTH			14. MOTHER'S MAIDEN NAME REBECCA SHIPP		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.) NO	16. SOCIAL SECURITY NO. 217-10-2543	17. INFORMANT & ADDRESS MRS. MABEL FORSYTH	HAGERSTOWN MD.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 196X IMMEDIATE CAUSE (A) Carcinoma of soft tissues of mandible. INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO _____ STATING UNDERLYING CAUSE LAST. (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None.					
19e. DATE OF OPERATION 1955.	19b. MAJOR FINDINGS OF OPERATION Carcinoma of mandible	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 8, 1954, to Mar. 27, 1956, that I last saw the deceased alive on Mar. 18, 1956, and that death occurred at 11:45 P.M. from the causes and on the date stated above. SIGNATURE <i>K. Preel</i> ADDRESS (Street, city, town, state) DATE SIGNED M.D. 119 N. Potomac St. Hagerstown, Md. 3-29-					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 3/31/56	NAME OF CEMETERY OR CREMATORIUM GREEN LAWN CEM.	LOCATION (City, town, or county) WILLIAMSPORT MD. (State) 56		
24. REC'D BY REGISTRAR DATE Apr. 2, 1956	REGISTRAR'S SIGNATURE <i>Beth Bowers</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment, Hagerstown, Md.</i>	ADDRESS		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3332

CERTIFICATE OF DEATH

Reg. Dist. No.

13313

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 18 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, R2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Goldie		First Marie	Middle Forsythe	Last Forsythe	4. DATE OF DEATH Month 3 Day 28 Year 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 18, 1898	9. AGE (In years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Cherry Run, W. Va.	
13. FATHER'S NAME Samuel Butts		14. MOTHER'S MAIDEN NAME Eliza Payne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Norman G. Forsythe Clearspring, Md. R2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X		REPTURE OF Aneurysm of circle of Willis in Brain INTERVAL BETWEEN ONSET AND DEATH 18 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 330X		(b)	DUE TO		
		(c)	DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Western Pike	(County) Hagerstown (State) rural
21. I certify that I attended the deceased from 3-27 , 19 56 , to 3-28 , 19 56 , that I last saw the deceased alive on March 28 , 19 56 , and that death occurred at 10:47 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Sidney Noyes		ADDRESS (Street, city or town, state) 210 Bowers Md. DATE SIGNED 3-29-56			
PHYSICIAN'S NAME (Type) SIDNEY NOYES, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-31-56	22c. NAME OF CEMETERY OR CREMATORIAL St. Pauls	22d. LOCATION (City, town, or county) (State) Western Pike Hagerstown rural	
23. FUNERAL DIRECTOR'S SIGNATURE Daymond Funeral Home		ADDRESS Jebel & Clark Clear Spring	24a. REC'D BY REGISTRAR Mar. 31, 1956		24b. REGISTRAR'S SIGNATURE Sherriff Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03314
Reg. Dist. No. 302

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 5 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Timothy	First Michael	Middle Gates	4. DATE OF DEATH Month March Day 9 Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 1, 1956
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James L. Gates		14. MOTHER'S MAIDEN NAME Marlene Snapp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James L. Gates		Address Funkstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration & dehydration DUE TO (c) Adrenal hyperplasia Patient from ovate		24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 145 W. Washington St. (County) Washington (State) Md.	
21. I certify that I attended the deceased from March 1, 1956 to March 9, 1956 , that I last saw the deceased alive on March 9, 1956 , and that death occurred at 8:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L.L. Packer		ADDRESS (Street, city or town, state) 145 W. Washington St. DATE SIGNED 3/9/56	
PHYSICIAN'S NAME (Type) Dr. L.L. Packer, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/56	
22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		24a. REC'D BY REGISTRAR Charles Bowers	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Charles Bowers	

BUREAU V. S.

MAR. 13 1956

KELLOGG'S BUREAU
MAR

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3380 CERTIFICATE OF DEATH

03315

Reg. Dist. No. 305

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Washington</i>	MARYLAND	STATE <i>Pa.</i>	COUNTY <i>FRANKLIN</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>X BOONSBORO R#2</i>	4 months	TOWN <i>WAYNESBORO</i>	<i>75X-3</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 FABRNEY-KEEDY HOME</i>	STREET ADDRESS <i>123 W. NORTH ST.</i>		
3. NAME OF DECEASED (Type or Print) <i>MARGARET M. GEARHART</i>		4. DATE OF DEATH <i>3/10 1956</i>	
S. SEX <i>FEMALE</i>	6. COLOR OF RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12/28/1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>77 yrs.</i>
13. FATHER'S NAME <i>BENJAMIN MUSSelman</i>		11. BIRTHPLACE (State or foreign country) <i>Midway Ohio</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>17. INFORMANT & ADDRESS</i> <i>George W. Ray, Boarder Rd. 2, MD.</i>	
18. MEDICAL CERTIFICATION <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1 IMMEDIATE CAUSE (A)</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 10 1956</i> to <i>March 10 1956</i> , that I last saw the deceased alive <i>March 10 1956</i> , and that death occurred at <i>7A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Al Weller</i> M.D.			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>3/13/56</i>	NAME OF CEMETERY OR CREMATORIAL <i>church of the BRETHREN</i>
24. REC'D BY REGISTRAR <i>John H. Rad.</i>		REGISTRAR'S SIGNATURE <i>John H. Rad.</i>	LOCATION (City, town, or county) <i>BROADFORDING</i>
DATE <i>March 12 1956</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Grose</i>	
		ADDRESS <i>Waynesboro Pa.</i>	

BUREAU V. S.

MR 15 1956

THE GENEVA CO.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03316

3334

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN lb 41 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland		d. STREET ADDRESS 314 N. Jonathan Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 N. Jonathan Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Major Ray Glascoe		First	Middle	Last	4. DATE OF DEATH 3 24 1956	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug 25 1913	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Martinburg W. Va.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME George W. Glascoe		14. MOTHER'S MAIDEN NAME Rose Bonnagh							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-9882		17. INFORMANT George Glascoe, Hagerstown Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute Pulmonary Edema		DUE TO 416X		INTERVAL BETWEEN ONSET AND DEATH minutes					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheum. Heart Disease		DUE TO (b)				years			
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. p. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)
21. I certify that I attended the deceased from May , 19 54 , to March , 19 56 , that I last saw the deceased alive on March 14 , 19 56 , and that death occurred at 1:45 AM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Howard N. Weeks, M.D.									
DATE SIGNED Howard N. Weeks									
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-1956		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr.		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Mar. 29, 1956		24b. REGISTRAR'S SIGNATURE Phast Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED APR 4 1956 **BUREAU V. S.**

APR 4 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03317

3335

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE									
Washington MARYLAND		Maryland.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		b. COUNTY Washington									
c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital Hagerstown Md.		d. STREET ADDRESS 204. W. High St Hancock Md.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle								
Sarah		Belle	Gordan								
4. DATE OF DEATH		Month	Day	Year							
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 19	Hours	Min.		
F		W		July 3. 1880							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Morgan County W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Peter Howvermale		14. MOTHER'S MAIDEN NAME Mathilda C Compton		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Frank C Gordan 204 W. High St Hancock Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 days	
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 170 W. Washington St., Hagerstown, Md.		(County)		(State)	
21. I certify that I attended the deceased from Mar 21, 1956, to Mar 22, 1956, that I last saw the deceased alive on Mar 22, 1956, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. S. Stauffer PHYSICIAN'S NAME (Type) R. S. STAUFFER										ADDRESS (Street, city or town, state) Berkeley Springs, W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3.25.56		22c. NAME OF CEMETERY OR CREMATORIAL Alpine Chapel Alpine W. Va.		22d. LOCATION (City, town, or county) Berkeley Springs, W. Va.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Howard & Son Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Mar. 27. 1956		24b. REGISTRAR'S SIGNATURE G. H. Boersch					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT - BUREAU OF MOTOR VEHICLE

CERTIFICATE OF DEATH

RECEIVED

BUREAU V.

MAR 29 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03318

3336

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	WASHINGTON LENGTH OF STAY (in this place) 7 years	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown Md.	COUNTY Washington (If rural give location) 1843 Virginia Ave.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1843 Virginia Ave.			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Robert Hamilton		March 23 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 20 1877
9. AGE last birthday 79 yrs.	10. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Williamsport Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Nelson Harsh	14. MOTHER'S MAIDEN NAME Sarah Redman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Mrs. Emma Harsh Hagerstown Md.	18. MEDICAL CERTIFICATION <i>Cocaine by Steven Bosis</i>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) Williamsport Md.	(County) Williamsport (State) MD
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from..... alive on....., and that death occurred at.....M, from the causes and on the date stated above. SIGNATURE <i>C. P. Gandy Jr.</i>			
23. BURIAL, CREMATION/ REMOVAL (SPECIFY) Burial	DATE THEREOF March 26-56	NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery	ADDRESS (Street, city, town, state) Williamsport Md.
24. REC'D BY REGISTRAR DATE Mar. 27, 1956	REGISTRAR'S SIGNATURE G. Harsh Baileya	25. FUNERAL DIRECTOR'S SIGNATURE Albert L. Legg	ADDRESS Williamsport Maryland

BUREAU V.

1956-68-88

LEGEND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03319

3337

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Washington MARYLAND		a. STATE Maryland	b. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1022 Potomac Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First OSCAR	Middle HARTSOCK
4. DATE OF DEATH March 11, 1956		Month	Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1897
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purch. Agent - Funkhouser Corp.		11. BIRTHPLACE (State or foreign country) Myersville, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Hartsock		14. MOTHER'S MAIDEN NAME Clara Earley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 14-09-1273	
17. INFORMANT Mrs. Marie A. Hartsock-1022 Potomac A.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c)		Coronary Occlusion Myocardial Infarction, Acute ONSET AND DEATH Instant Not determined	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 28, 1956, to March 11, 1956, that I last saw the deceased alive on Feb. 25, 1956, and that death occurred at 12:05 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. B. Kneisley</i> PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D. ADDRESS (Street, city or town, state) 148 West Washington Street DATE SIGNED 3/12/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-15-56	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE Mar. 14, 1956	
		24b. REGISTRAR'S SIGNATURE <i>West. Bowers</i>	

WILMINGTON STATE DEPARTMENT OF HEALTH—BALTIMORE

BUREAU V. S.

MAR 16 1956

REGELVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03320

Dr. Wells

3338

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 643 Guilford Ave.				d. STREET ADDRESS 643 Guilford Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EMMA		First ELIZABETH	Middle HOUSER	Last 	4. DATE OF DEATH March 28,	Month Day	Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 25, 1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) nr. Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William H. Cooper			14. MOTHER'S MAIDEN NAME Elizabeth Shilling					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Leon Houser		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic myocardial INTERVAL BETWEEN ONSET AND DEATH 20 yrs 443X DUE TO Heart Disease								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Acute Ventricular Fibrillation								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month none	Day 19	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) 	(County) 	(State)
21. I certify that I attended the deceased from October, 1940 , to March 28, 1956 , that I last saw the deceased alive on March 21, 1956 , and that death occurred at 643 Guilford Ave. , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>S. Robert Wells MD</i>								
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-30-56	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery			22d. LOCATION (City, town, or county) Hagerstown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Md.				ADDRESS	24a. REC'D BY REGISTRAR Mar 30, 1956	24b. REGISTRAR'S SIGNATURE <i>Chief Recorder</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	55	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
1015 E. 36TH ST.	BALTIMORE	MARYLAND	
NAME OF DOCTOR	STREET	CITY	STATE
DR. JAMES M. COOPER	1015 E. 36TH ST.	BALTIMORE	MARYLAND
NAME OF FUNERAL DIRECTOR	STREET	CITY	STATE
JOHN W. COOPER	1015 E. 36TH ST.	BALTIMORE	MARYLAND
NAME OF CHURCH	STREET	CITY	STATE
CHRISTIAN CHURCH	1015 E. 36TH ST.	BALTIMORE	MARYLAND
NAME OF CEMETERY	STREET	CITY	STATE
WOODLAWN CEMETERY	1015 E. 36TH ST.	BALTIMORE	MARYLAND
DATE OF DEATH	TIME	AGE	WEIGHT
APRIL 3, 1956	10:00 A.M.	55	160 lbs
TIME OF DEATH	TIME OF BURIAL	TIME OF EXHUMATION	TIME OF REINTERMENT
10:00 A.M.	10:30 A.M.		
RECEIVED	RECEIVED	RECEIVED	RECEIVED
BUREAU V. S.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3339 CERTIFICATE OF DEATH

103321

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 39 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 862 MULBERRY AVE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 862 MULBERRY AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EDGAR MARTIN HUNTZBERRY		First	Middle	Last	4. DATE OF DEATH MARCH - 20 - 1956	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9 - 1891	9. AGE (In years last birthday) 64 - 4 - 11 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAIL CARRIER U.S.P.O.		10b. KIND OF BUSINESS OR INDUSTRY U.S.P.O.		11. BIRTHPLACE (State or foreign country) HAGERSTOWN MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HOWARD M. HUNTZBERRY		14. MOTHER'S MAIDEN NAME RACHAEL RAUTZAHN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS PHOEBE HUNTZBERRY		Address 862 MULBERRY AVE HAGERSTOWN MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH 15 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Arteria reducta heart disease				 15 yrs		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro Cemetery		20f. (City or town) Boonsboro		(County) WASH. Co. (State) MD
21. I certify that I attended the deceased from 1/1/56 , 1956, to 2/2/56 , 1956, that I last saw the deceased alive on 14 Mar 56 , 1956, and that death occurred at 115 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Hagerstown MD		DATE SIGNED 3/2/56		
ACTUAL SIGNATURE Eldred Goodlin		M.D. Eldred Goodlin						
PHYSICIAN'S NAME (Type) Eldred Goodlin								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 23, 1956		22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) Boonsboro WASH. Co. MD		(State)
23. FUNERAL DIRECTOR'S SIGNATURE BEST FUNERAL HOME		ADDRESS Boonsboro MD		24a. REC'D BY REGISTRAR Mar. 27, 1956		24b. REGISTRAR'S SIGNATURE Frank Powers		

CERTIFICATE OF DEATH

1930

RECEIVED
MAY 27 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03322

Reg. Dist. No. 302

Dr. Hocklander

3340

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 08 444 Carrollton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA		First ELTON	Middle JENKINS
		Last JENKINS	4. DATE OF DEATH March 5 1956
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 25, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Front Royal, Virginia USA
13. FATHER'S NAME Daniel Robison		14. MOTHER'S MAIDEN NAME Nancy Ann Robison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Norman Jenkins-15½ Madison Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO Coronary Thrombosis } (c) DUE TO Hypertension		INTERVAL BETWEEN ONSET AND DEATH 4 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/1/56 , to 5/1/56 , that I last saw the deceased alive on 5/1/56 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 115 W. Wash St	
ACTUAL SIGNATURE Eldridge Howard M.D.		DATE SIGNED 3/6/56	
PHYSICIAN'S NAME (Type) Eldridge Howard Hocklander			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-56	22c. NAME OF CEMETERY OR CREMATORIUM Edge Hill Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		ADDRESS	24a. REC'D BY REGISTRAR Mar. 8, 1956
			24b. REGISTRAR'S SIGNATURE Sparrt. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. BONAVENTURE UNIVERSITY POLYGRAPHIC STATE OWNERSHIP

BUREAU V.

MAR 12 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03323

Dr. Jennings

3381

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gonocochague		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		d. STREET ADDRESS 530 North Mulberry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WINIFRED		First	Middle	Last	4. DATE OF DEATH March 6, 1956	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 21, 1897	9. AGE (In years lost birthday) yrs. 59	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Racine, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry A. Bonig				14. MOTHER'S MAIDEN NAME No Record					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Claude W. Karn-173 Summit Ave.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Presenile Psychosis - Alzheimer's Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 136 W. Washington St		20f. (City or town) Hagerstown, Maryland		(County) Hagerstown	(State) Maryland
21. I certify that I attended the deceased from Oct. 3, 1952 , to March 6, 1956 , that I last saw the deceased alive on March 5, 1956 , and that death occurred at 3:25 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE George Jennings MD		ADDRESS (Street, city or town, state) 136 W. Washington St		DATE SIGNED 3/7/56					
PHYSICIAN'S NAME (Type) Dr. George Jennings									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Mar 9-56		24b. REGISTRAR'S SIGNATURE Lucy M. Storkes Deputy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03324

3341

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 16 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LAURA	Middle LOOSE	Last KEEDY
4. DATE OF DEATH March	Month March	Day 7	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 29, 1872
			9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry C. Loose		14. MOTHER'S MAIDEN NAME Virginia Pearson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Virginia Boward
		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
DUE TO 443X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis - Generalized		DUE TO 2 yrs +.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Hagerstown		(County) Maryland	
		(State)	
21. I certify that I attended the deceased from Sept. 19, 1955 to Mar. 7, 1956 , that I last saw the deceased alive on Mar. 7, 1956 , and that death occurred at 6:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hagerstown, MD	
ACTUAL SIGNATURE Lloyd A. Hoffman		DATE SIGNED 3/8/56	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/1956	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Sister Mary Magdalene Conroy		24a. REC'D BY REGISTRAR Mar 10, 1956	24b. REGISTRAR'S SIGNATURE Frank Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE
CIVILIAN PERSONNEL BOARD

CERTIFICATE OF DEATH

RECEIVED
U.S. GOVERNMENT PRINTING OFFICE
1956 MAR 13 1956

BUREAU V. S.

MAR 13 1956

RECEIVED

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03325

3342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Washington MARYLAND		a. STATE Maryland	b. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb <u>½ hr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First George William Kerns, Sr.	Middle Last Month Day Year
4. DATE OF DEATH		March 13	19 56
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 23, 1887
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		B & O R.R.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Martinsburg, W. Va. USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Harry F. Kerns		Mary Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Mrs. Vallie M. Kerns - 19 E. Franklin St	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic myocardial hearat disease</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
Severe Bronchial Asthma			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) -----	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		March 14 '56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-56	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Wash., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Maryland	
24a. REC'D BY REGISTRAR <i>Mar. 19 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Frank Boever</i>	

BUREAU V. S.

JAN 21 1956

REGIV ED MAR 21 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03326

3343

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN lb 28 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 14 Snyder Ave.,			d. STREET ADDRESS 14 Snyder Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Kidwiler	4. DATE OF DEATH 3 25 1956	Month Day Year
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1878	9. AGE (In years old/birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Milton Long			14. MOTHER'S MAIDEN NAME Mary Elizabeth Barton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Sarah Campbell	Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO cause (a), stating the under- lying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH Days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) (State)
21. I certify that I attended the deceased from 3/24/56 19 to 3/25/56 19, that I last saw the deceased alive on 3/25/56 19, and that death occurred at 8:40 PM, from the causes and on the date stated above.					
ACTUAL SIGNATURE Balfry Young		ADDRESS (Street, city or town, state) Wellington, Md. DATE SIGNED 3/26/56			
PHYSICIAN'S NAME (Type) burial		22a. BURIAL, CREMATION, REMOVAL (Specify) burial			
22b. DATE THEREOF 3-28-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Knaiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar. 28, 1956	
24b. REGISTRAR'S SIGNATURE Kirsten Bowers					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
APR 2 1956				
BUREAU V. S.				
FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE				
WASH. 25, D. C.				
APR 2 1956				
RECEIVED				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03327

Reg. Dist. No. 302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerst OWN		d. STREET ADDRESS 322 Liberty St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 322 Liberty St.				d. STREET ADDRESS 322 Liberty St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First Raphael Koontz		Last		4. DATE OF DEATH March		Month Day Year 28 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 26, 1905	9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) Fiddlersburg Md.			
13. FATHER'S NAME James Koontz		14. MOTHER'S MAIDEN NAME Irene Beard					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-6020		17. INFORMANT Mrs. Irene S. Koontz		Address Hag. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Acute Coronary thrombosis					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)					
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		None				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour a. m. p. m. - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) — — — —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>S. Robert Wells</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 28 '56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich Son Hag. Md.		ADDRESS SCOTT F. MINNICH & SON HAG. MD.		24a. REC'D BY REGISTRAR APR. 2, 1956		24b. REGISTRAR'S SIGNATURE Chas. Beavers	

MANUFACTURED BY THE STATE OF HAWAII
HAWAII STATE EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03328

3345

CERTIFICATE OF DEATH

Dr Novenstein

Reg. Dist. No.

303

1. PLACE OF DEATH

o. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

2 Days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Wash. County Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. STREET ADDRESS

1094 So Potomac St

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

EVA

MARIA

KRETZER

First Middle Last

4. DATE OF DEATH

March 24 1956

Day Year

5. SEX

Female White

6. COLOR OR RACE

WIDOWED 7. MARRIED NEVER MARRIED DIVORCED

8. DATE OF BIRTH

August 5 1874

9. AGE (In years
last birthday)
yrs.

81

10. IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Sharpsburg Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James Kemp

14. MOTHER'S MAIDEN NAME

Sarah Shafer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

E. Kemp Kretzer Hagerstown Md

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

570.5

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

3-20-56

MEDICAL CERTIFICATION

artery sclerosis heart disease

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
White Not white
at work off work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that I attended the deceased from Mar. 16, 1956, to Mar. 24, 1956, that I last saw the deceased alive on Mar. 24, 1956, and that death occurred at 2:55 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Sidney Novenstein M.D.

Tuckerman Md

3-24-56

PHYSICIAN'S
NAME (Type)

SIDNEY NOVENSTEIN

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

3/27/56

22b. DATE THEREOF

Mt. View Cemetery

22d. LOCATION (City, town, or county)

(State)

Sharpsburg Wash. Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Andrew K. Goffman Hagerstown Md.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

DATE

AMERICAN STATE DEPARTMENT OF HELLIN - GULINORE 18

CERTIFICATE OF DEATH

WITNESSED

BY THE SECRETARY

OR HIS DEPUTY

OR HIS AGENT

OR HIS ATTACHE

OR HIS CONSUL

OR HIS CONSUL GENERAL

RECORDED

SEARCHED

INDEXED

SERIALIZED

FILED

BUREAU Y. S.

MAR 23 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3382 CERTIFICATE OF DEATH

03329

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND		b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BOONSBORO		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		d. STREET ADDRESS N. MAIN ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 N. MAIN ST.				d. STREET ADDRESS N. MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPHINE - ELIZABETH LAKIN		First	Middle	Last	4. DATE OF DEATH MARCH - 20 - 1956	Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH OCTOBER-20-1867	9. AGE (In years last birthday) 88-5-0 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BOONSBORO WASH. Co. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME DR. A. WILL		14. MOTHER'S MAIDEN NAME JOSEPHINE TROUP.				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 41 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Generalized arteritis, scleroderma (c)		Chronic myocarditis.				INTERVAL BETWEEN ONSET AND DEATH 1 mo. 11 days			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>February 9th, 1956</u> , to <u>March 20th, 1956</u> , that I last saw the deceased alive on <u>March 13th, 1956</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. Hubert Wade.</u> PHYSICIAN'S NAME (Type) <u>J. Hubert Wade. M. D.</u>				ADDRESS (Street, city or town, state) <u>25 Main St. Boonsboro Md.</u>		DATE SIGNED <u>3-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 23 1956		22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) Boonsboro WASH. Co. MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE BAST FUNERAL HOME Boonsboro MD.		ADDRESS		24a. REC'D BY REGISTRAR DATE Mar. 22. 1956		24b. REGISTRAR'S SIGNATURE John H. Bast			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3346

CERTIFICATE OF DEATH

03330

Reg. Dist. No. 302

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end with town) TOWN	WASHINGTON	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND	COUNTY WASHINGTON
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL			STREET ADDRESS 1 S. CLEVELAND AVE.		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) LOUISE			(Month) MARCH (Day) 18 (Year) 56		
(Middle)			(Last)		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	B. DATE OF BIRTH 5/10/1914	9. AGE last birthday 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME HUBERT L. KELLER			14. MOTHER'S MAIDEN NAME GRACE BELLE SAUM		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.) NO			16. SOCIAL SECURITY NO. 214-09-8467	17. INFORMANT & ADDRESS MR. JOHN LOOKABAUGH HAGERSTOWN MD.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Carcinoma Breast &</i> ANTECEDENT CAUSE(S) DUE TO <i>metastasis to lung bone</i> DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO _____ STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19e. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 1956</i> , to <i>March 18, 1956</i> , that I last saw the deceased alive on <i>July 1956</i> , and that death occurred at <i>Hagerstown Md.</i> from the causes and on the date stated above. SIGNATURE <i>Jules J. Gleason</i> M. D. ADDRESS <i>Hagerstown Md.</i> DATE SIGNED <i>3/19/56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 3/20/56	NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEM.	LOCATION (City, town, or county) HAGERSTOWN MD.	
24. REC'D BY REGISTRAR DATE <i>Mar. 21, 1956</i>		REGISTRAR'S SIGNATURE <i>Chas. T. Gowers</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>W. J. Kornblut, Hagerstown, Md.</i>		

BY PROCLAMATION OF THE STATE CHAIRMAN

STATE TO STATE

RECEIVED

RECEIVED BY THE STATE CHAIRMAN

THE STATE CHAIRMAN

RECEIVED BY THE STATE CHAIRMAN

BUREAU U. S.

MAR 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03331
302

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 2. File No. 3347-56 et

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Home				d. STREET ADDRESS 715 Washington Ave. Washington Co. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles Roland Manious		First Charles	Middle Roland	Last Manious	4. DATE OF DEATH Month 3	Day 3	Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 6, 1882	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Adam Manious		14. MOTHER'S MAIDEN NAME Indiana Eichelberger						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles J. Manious		Address Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart disease 420.0 DUE TO With myocardial failure INTERVAL BETWEEN ONSET AND DEATH 5 yrs + Conditions, if any, which gave rise to immediate cause (a), sloing the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 230 N Potowmack		20f. (City or town) Hagerstown	(County) Washington	(State) Md.
21. I certify that I attended the deceased from Feb , 19 46 , to 3 Mar , 19 56 , that I last saw the deceased alive on 2 Mar , 19 56 , and that death occurred at 4:57 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE F.F. Lusby ADDRESS (Street, city or town, state) M.D. 230 N Potowmack								DATE SIGNED 3 Mar 56
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Mar 7 1956		24b. REGISTRAR'S SIGNATURE Spess. H. Baileys		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Date of death

Cause of death

Name of deceased

Name of physician

Age at death

Name of deceased

Name of physician

Place of death

Name of deceased

Name of physician

Date of birth

Name of deceased

Name of physician

Cause of death

Name of deceased

Name of physician

Age at death

Name of deceased

Name of physician

Place of death

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Cause of death

Name of deceased

Name of physician

Age at death

Name of deceased

Name of physician

Place of death

Name of deceased

Name of physician

Date of birth

Name of deceased

Name of physician

Cause of death

Name of deceased

Name of physician

Age at death

Name of deceased

Name of physician

Place of death

Name of deceased

Name of physician

Date of birth

Name of deceased

Name of physician

BUREAU V. 2

MAR 9 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03332

3383

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY		Washington Co MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		Md.	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY	
TOWN		Rural Surface 18 months		TOWN		Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Hagerstown Md Rd 4		STREET ADDRESS		Rural Surface	
3. NAME OF DECEASED (Type or Print)		(First) ALBERT (Middle) S (Last) MARTIN		4. DATE OF DEATH		Month Mar	Day 24
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower		8. DATE OF BIRTH Nov. 20 1876	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Retired Farmer		None		Mercersburg Pa Rd 2		USA	
13. FATHER'S NAME David J. Martin		14. MOTHER'S MAIDEN NAME Sarah Eckert		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS John Martin, Mercersburg Pa Rd 2		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

452.0
Immediate cause

(a)

Congestive Failure
Senile arteriosclerosis
Osteoarthritis

2 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
INJURY		TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Sept. 20, 1955, to March 24, 1956, that I last saw the deceased

alive on March 24, 1956, and that death occurred at 10:17 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)	
Burial		Mar. 27-56		Brother's Cemetery		Welsh Run Franklin		Pa	
DATE REC'D BY LOCAL REG. OFF.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			

BUREAU V. S.

MAR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03333
302

3348

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. If either, notify medical examiner.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 106 W. Bethel Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Cornelius		First (no)	Middle 	Last McKenzie	4. DATE OF DEATH Mar 27 1956	Month Mar	Day 27	Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec 26 1891	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Sunter, S.C.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Lawrence McKenzie		14. MOTHER'S MAIDEN NAME Leona McDonald		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary occlusion Cerebral Hemorrhage Pneumonia.		INTERVAL BETWEEN ONSET AND DEATH 1 wk			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Hagerstown	(State) Maryland	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from Feb. 17 , 1956, to March 27, 1956 , that I last saw the deceased alive on March 27 , 1956, and that death occurred at 12 N. Market from the causes and on the date stated above.		ACTUAL SIGNATURE John R. Watson		ADDRESS (Street, city or town, state) 159 W. Washington St.		DATE SIGNED 3/31/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-1956		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Apr. 2, 1956		24b. REGISTRAR'S SIGNATURE Robert Powers					

CERTIFICATE OF DEATH

REGISTRATION
NUMBER

DECEASED

DEATH DATE

NAME OF PERSON REPORTING DEATH

RELATIONSHIP TO DECEASED

ADDRESS OF PERSON REPORTING DEATH

CITY, STATE, ZIP CODE

PHONE NUMBER

NAME OF PERSON REPORTING DEATH

RELATIONSHIP TO DECEASED

ADDRESS OF PERSON REPORTING DEATH

CITY, STATE, ZIP CODE

PHONE NUMBER

NAME OF PERSON REPORTING DEATH

RELATIONSHIP TO DECEASED

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RELATIONSHIP TO DECEASED

ADDRESS OF PERSON REPORTING DEATH

CITY, STATE, ZIP CODE

PHONE NUMBER

NAME OF PERSON REPORTING DEATH

RELATIONSHIP TO DECEASED

ADDRESS OF PERSON REPORTING DEATH

CITY, STATE, ZIP CODE

PHONE NUMBER

NAME OF PERSON REPORTING DEATH

RELATIONSHIP TO DECEASED

ADDRESS OF PERSON REPORTING DEATH

CITY, STATE, ZIP CODE

PHONE NUMBER

BUREAU Y.

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103334

3349

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 758 Jefferson St.				d. STREET ADDRESS 930 Jefferson Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Lee	Last Miller	4. DATE OF DEATH March	Month March	Day 29	Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1883	9. AGE (In years by birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Martinsburg		12. CITIZEN OF WHAT COUNTRY? W. Va. U. S. A.		
13. FATHER'S NAME Edward O. Williams			14. MOTHER'S MAIDEN NAME Octavia J. Snyder			Address Hagerstown Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Christian A. Miller		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Arteriosclerosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 318 N. Potomac St. Hagerstown		(State) MD.
21. I certify that I attended the deceased from July 1955 to Death 1956 , that I last saw the deceased alive on 3-28-1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Paul Harrison ADDRESS (Street, city or town, state) 318 N. Potomac St. PHYSICIAN'S NAME (Type) PAUL HARRISON, M. D. DATE SIGNED Hagerstown Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hag. Md.			ADDRESS			24a. REC'D BY REGISTRAR Apr. 2nd 1956		
						24b. REGISTRAR'S SIGNATURE Joseph Bowers		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 4 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03335

3384

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X MAPLEVILLE		c. LENGTH OF STAY IN 1b 9 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAPLEVILLE		d. STREET ADDRESS X AT HOME					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 58 AT HOME				d. STREET ADDRESS MAPLEVILLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LEWIS DAWSON		First	Middle	Lost	4. DATE OF DEATH MARCH - 6 - 1956	Month	Doy	Year			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH DECEMBER - 6 - 1885 - 70 - 3 yrs.	9. AGE (In years lost birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) FREDERICK CO. MD.			
13. FATHER'S NAME CHARLES MILLER		14. MOTHER'S MAIDEN NAME SARAH DEBR		12. CITIZEN OF WHAT COUNTRY? U.S.A.		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. 217-28-7317		17. INFORMANT MRS. BETTIE MILLER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma of Prostate. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 Yrs. 1 Mo.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro, Md.		20f. (City or town) Boonsboro, Md.		(County) Boonsboro, Md.		(State) MD.	
21. I certify that I attended the deceased from Feb. 6, 1956 , to March 6, 1956 , that I last saw the deceased alive on March 5, 1956 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro, Md.											DATE SIGNED 3/7/56
ACTUAL SIGNATURE <i>J. Hubert Wade.</i>		M.D.									
PHYSICIAN'S NAME (Type) J. Hubert Wade, M. D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 9, 1956		22c. NAME OF CEMETERY OR CREMATORIUM LUTHERAN CEMETERY		22d. LOCATION (City, town, or county) MIDDLETON FRED. CO. MD.		(State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE BEST FUNERAL HOME		ADDRESS Boonsboro MD.		24a. REC'D BY REGISTRAR DATE MARCH 8 1956		24b. REGISTRAR'S SIGNATURE <i>John H. Best</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03336

3350

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN lb 51 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 03	
d. STREET ADDRESS 32 N. Cleveland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Vernon	Middle Monroe	Last Miller
4. DATE OF DEATH	Month March	Day 18	Year 1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 6, 1890
9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (State or foreign country) Rileyville Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin Miller		14. MOTHER'S MAIDEN NAME Isabelle Brewer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-0433 Mrs. Irene Miller Hagerstown Md.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 420.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis, acute DUE TO (c) Coronary arteriosclerosis		3 hrs. Undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 18, 1956, to March 18, 1956, that I last saw the deceased alive March 18, 1956, and that death occurred at 5:40 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE John H. Kehne M.D. ADDRESS (Street, city or town, state) DATE SIGNED 3/19/56			
PHYSICIAN'S NAME (Type) John H. Kehne, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-56	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hag, Md.		24a. REC'D BY REGISTRAR Mar. 22, 1956	
		24b. REGISTRAR'S SIGNATURE John H. Gowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03337

3385 CERTIFICATE OF DEATH

Reg. Dist. No. 307

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <input checked="" type="checkbox"/> TOWN	Washington Dargan	MARYLAND LENGTH OF STAY (in this place) Life	STATE CITY TOWN STREET ADDRESS Maryland Dargan Mountain Lock (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <input checked="" type="checkbox"/>	Residence			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		
(First) MARTHA		(Middle) ESTELLA	(Last) MYERS	
5. SEX <input checked="" type="checkbox"/> Female	6. COLOR OR RACE <input checked="" type="checkbox"/> White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 22, 1870	
9. AGE last birthday 85 yrs.	10. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pleasantville, Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Thompson	14. MOTHER'S MAIDEN NAME Lucy Ingram			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <input checked="" type="checkbox"/> No	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> None	17. INFORMANT & ADDRESS David W. Myers Box 92, R.F.D. #1, Harpers Ferry, W. Va.	INTERVAL BETWEEN ONSET AND DEATH 1 month	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
450.0 IMMEDIATE CAUSE <input checked="" type="checkbox"/>	(A) <u>Infected decubitus ulcers</u>			
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	(B) <u>cachexia</u>		
(C) <u>Generalized arteriosclerosis</u>				6 months
				20 Yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH...				20 Yrs.
19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Chronic non specific bronchitis			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from.....1930....., 19....., to.....March 4, 1956....., that I last saw the deceased alive on.....3/2/56....., 19....., and that death occurred at.....8:45AM....., from the causes and on the date stated above.				
SIGNATURE <i>W. H. Shealy</i>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3/7/56	NAME OF CEMETERY OR CREMATORIAL Samples Manor Cemetery	LOCATION (City, town, or county) Samples Manor, Maryland	(State)
24. REC'D BY REGISTRAR DATE Mar. 6 - 1956	REGISTRAR'S SIGNATURE Katherine Daugherty	25. FUNERAL DIRECTOR'S SIGNATURE Donald Packless ADDRESS Harpers Ferry, West Virginia		

DEPARTMENT OF INTERNAL SECURITY
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

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FEDERAL BUREAU OF INVESTIGATION

MAR 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Ralph Young 04499
Reg. Dist. No. 805

3351

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 457 W. Washington St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALICE	Middle JORDAN	Last O'CONNELL	4. DATE OF DEATH March 31 1956 19	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH October 13 1892	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pittsburg Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Record			14. MOTHER'S MAIDEN NAME No Record				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Ernest N. O'Connell Hagerstown Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung & metastasis INTERVAL BETWEEN ONSET AND DEATH 163X DUE TO 6 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input type="checkbox"/>							
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County)	(State)
21. I certify that I attended the deceased from 2/27/56 to 3/31/56 , that I last saw the deceased alive on 3/31/56 , 19, and that death occurred at 8:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Ralph Young M.D. ADDRESS (Street, city or town, state) Wellington East Md DATE SIGNED 3/31/56 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/3/56	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				ADDRESS	24a. REC'D BY REGISTRAR 6/2/56, 1956	24b. REGISTRAR'S SIGNATURE Joseph Bowes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH—SATURDAY, 18

CERTIFICATE OF DEATH

DEATH CERTIFICATE

REGISTRATION

BUREAU V. S.

APR 9 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103338

3352

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Washington</i>		a. STATE <i>Md.</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Hagerstown</i>		<i>Knoxville</i> 10X 21	
c. LENGTH OF STAY IN 1b <i>4 days</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Co. Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>ELIZABETH</i>	Last <i>OLDEN</i>
4. DATE OF DEATH	Month <i>3</i>	Day <i>28</i>	Year <i>1956</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female</i>	<i>white</i>	<i>WIDOWED</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>Sept. 5, 1885</i>
9. AGE (In years lost birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Edward Fredericks</i>		14. MOTHER'S MAIDEN NAME <i>Mary Camel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>James Olden, Frederick, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i>		DUE TO <i>Uremia</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. } (b) <i>Debt & Arteriosclerosis & C.V.A.</i>		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/23, 1954</i> , to <i>3/25, 1956</i> , that I last saw the deceased alive on <i>3/28/56</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard N. Weeks, M.D.</i>		ADDRESS (Street, city or town, state) <i>136 N. Potomac St., Hagerstown, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Howard N. Weeks, M.D.</i>		DATE SIGNED <i>3/28/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-30-1956</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Ch. of B Cemetery</i>		22d. LOCATION (City, town, or county) <i>Brownsville</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill C.</i>		ADDRESS <i>Middleton, Md.</i>	
24a. REC'D BY REGISTRAR <i>Mar. 30, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Charles H. Bassett Boowers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
APR 3 1956

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3353 CERTIFICATE OF DEATH**

03339

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY	
Washington				Maryland		Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown			
Hagerstown		2 weeks		Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Washington County Hospital		62½ Wayside Ave.							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
		GEORGE	WHITAKER	POWELL	March		1	56	
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	September 12, 1907	48 yrs.	5 Months	19 Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Die Maker		Aircraft Company		Bedford, Pennsylvania		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Frank Powell		Amelia Gardill							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(If yes, give war or dates of service)		716-05-7171		Mrs. Helen S. Powell		Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion					5 hours		
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Stricture of Common Bile Duct					3 yrs		
DUE TO cause (b)		Arteriosclerotic heart disease					70		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Cholelithiasis									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that I attended the deceased from <u>Feb 12, 1956</u> , to <u>Mar 1, 1956</u> , that I last saw the deceased alive on <u>March 1, 1956</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE	John A. Moran M.D. M.D.					215 W. Washington St.		3/2/56	
PHYSICIAN'S NAME (Type)	John A. MORAN M.D.					Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial	3/4/1956	Rose Hill Cemetery		Hagerstown, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
John A. Moran	Hagerstown, Maryland		Date Mar 3, 1956		Robert H. Powers				

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital attending physician.

O FUNERAL DIRECTOR: After this affidavit has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HAWAII - TELEGRAMS

CHIEF STATE OF DEATH

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BUREAU V. S.

MAR 6 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician or hospital, completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03340

3354 CERTIFICATE OF DEATH

302

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN HAGERSTOWN		STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAGERSTOWN	
LENGTH OF STAY <small>(in this place)</small> LIFE		STREET ADDRESS <small>(if rural give location)</small> 5 ENGLEWOOD ROAD	
3. NAME OF DECEASED <small>(First) (Middle) (Last)</small> LE WATTS REAGAN		4. DATE OF DEATH <small>(Month) (Day) (Year)</small> MARCH 5 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <small>(Specify)</small> WIDOWED	8. DATE OF BIRTH 4/9/1882
<small>10b. OCCUPATION (Give kind of work done during most of working life, even if retired)</small> SEAMSTRESS		<small>10b. KIND OF BUSINESS OR INDUSTRY</small> TAILOR SHOP	
<small>11. BIRTHPLACE (State or foreign country)</small> MARYLAND		<small>12. CITIZEN OF WHAT COUNTRY?</small> U.S.A.	
<small>13. FATHER'S NAME</small> JOHN A. MILLER		<small>14. MOTHER'S MAIDEN NAME</small> SARAH WELSH	
<small>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</small> <small>(Yes, No, unk.)</small> No		<small>16. SOCIAL SECURITY NO.</small> 162-22-9923	
<small>17. INFORMANT & ADDRESS</small> Mr. Tom MILLER		<small>18. MEDICAL CERTIFICATION</small> <i>Nutrition</i> <i>Metastatic carcinoma</i> <i>Carcinoma of Cervix</i>	
<small>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</small> 171X IMMEDIATE CAUSE <small>(A)</small> <small>ANTECEDENT CAUSE(S)</small> DUE TO <small>DISEASES OR CONDITIONS, IF ANY,</small> DUE TO <small>GIVING RISE TO THE ABOVE CAUSE</small> <small>STATING UNDERLYING CAUSE LAST.</small> DUE TO <small>(B)</small> <small>(C)</small>		<small>INTERVAL BETWEEN ONSET AND DEATH</small> 3 months 3 yrs. 6 yrs	
<small>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</small>			
19a. DATE OF OPERATION 1950	19b. MAJOR FINDINGS OF OPERATION		
<small>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		<small>21b. PLACE (Home, farm, factory, office, shop, etc.)</small> <small>Whila at work <input type="checkbox"/> Not while at work <input type="checkbox"/></small>	
<small>21c. WHERE DID INJURY OCCUR? (City or town)</small> <small>(County) (State)</small>			
<small>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</small> <small>M.</small>		<small>21e. INJURY OCCURRED</small> <small>Whila at work <input type="checkbox"/> Not while at work <input type="checkbox"/></small>	
		<small>21f. HOW DID INJURY OCCUR?</small>	
<small>22. I hereby certify that I attended the deceased from January 2, 1950, to death, 19....., that I last saw the deceased alive on 3-3-1956, and that death occurred at 11:04 AM, from the causes and on the date stated above.</small>			
<small>SIGNATURE</small> <i>Robert F. Keade</i>		<small>ADDRESS (Street, city, town, state)</small> Hagerstown 132 W. Main	
		<small>DATE SIGNED</small> 3-6-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 3/7/56	NAME OF CEMETERY OR CREMATORIAL FUNKSTOWN CEM.	LOCATION (City, town, or county) FUNKSTOWN MD.
24. REC'D BY REGISTRAR Mac 9 1956	REGISTRAR'S SIGNATURE Joseph Bowers	25. FUNERAL DIRECTOR'S SIGNATURE W. J. Kornreich, Hagerstown, Md.	
<small>ADDRESS</small>			

RECEIVED - STATEMENT OF EXPENSES
BY THE STATE GOVERNOR

CERTIFICATE OF EXPENSES

RECEIVED - STATEMENT OF EXPENSES
BY THE STATE GOVERNOR

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BUREAU

MAR 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03341

Dr. Warden

3355

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Hagerstown		c. LENGTH OF STAY IN 1b 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 81 Washington Co. Hospital			d. STREET ADDRESS Downsville Pike		
3. NAME OF DECEASED (Type or print) REUBEN WALTER REED			4. DATE OF DEATH Month Day Year March 11, 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 21, 1883	9. AGE (In years at birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Self-employed		
11. BIRTHPLACE (State or foreign country) Castlemann, Penna.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jesse Reed			14. MOTHER'S MAIDEN NAME Alice Gebhart		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 15-36-7166		17. INFORMANT Mr. Harry G. Reed - Hagerstown R#3 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia INTERVAL BETWEEN ONSET AND DEATH 10 days					
180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma kidney ? / DUE TO (c) Carcinoma left kidney 3 years DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-23-56, 19, to 3-11-56, 19, that I last saw the deceased alive on 3-11-56, 19, and that death occurred at 11:15PM from the causes and on the date stated above. ACTUAL SIGNATURE J. G. Warden M.D. ADDRESS (Street, city or town, state) 3-12-56 DATE SIGNED					
PHYSICIAN'S NAME (Type) J. G. Warden, M. D. 832 Potomac Ave., Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-14-56	22c. NAME OF CEMETERY OR CREMATORIUM Green Lawn Cemetery	22d. LOCATION (City, town, or county) Williamsport, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland			24a. REC'D BY REGISTRAR Mar 14, 1956	24b. REGISTRAR'S SIGNATURE G. H. Beavers	

81 APPROPRIATE-ITM-90 CHARTER STATE QUARANTINE

BUREAU V. S.

MAR 16 1956

MEGELVÉ

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
File Pages 1 and 2 with the registrar prior to burial, cremation,
or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
3386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. <u>305</u>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mapleville</u>			c. LENGTH OF STAY IN 1b <u>11 mos</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mapleville, Maryland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at home - Mapleville, Md.</u>						d. STREET ADDRESS <u>-</u>					
3. NAME OF DECEASED (Type or print) <u>Finn Howard Emory</u>		4. DATE OF DEATH <u>March 2 1956</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1891</u>		9. AGE (In years from birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR <u>Months</u> IF UNDER 24 HRS. <u>Days</u> HOURS <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Samuel Reese</u>						14. MOTHER'S MAIDEN NAME <u>Armenia Castle</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-36-6973</u>			17. INFORMANT <u>Mrs. Ralph Rice - Daughter - Mapleville, Md.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation due to hanging</u> INTERVAL BETWEEN ONSET AND DEATH <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>(b)</u> <u>(c)</u> DUE TO <u>(c)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u> 19. WAS AUTOPSY PERFORMED? <u>NO</u> <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self with rope in barn</u>								
20c. TIME OF INJURY Month, Day, Year <u>Hour 3:06</u> <u>Mar. 2 1956</u>			20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barn</u>			20f. (City or town) (County) (State) <u>Mapleville Wash. Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.											
MEDICAL CERTIFICATION ACTUAL SIGNATURE <u>S. Robert Wells</u> DATE SIGNED <u>March 3 '56</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-56</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Beaver Creek</u>			22d. LOCATION (City, town, or county) (State) <u>Beaver Creek Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>						ADDRESS <u>Boonsboro, Md.</u>			24a. REC'D BY REGISTRAR <u>John H. Best</u> DATE <u>Mar. 4, 1956</u>		

RECEIVED - MEDICAL EQUIPMENT - STATE OF DEATH

BUREAU V. S.
RECEIVED
MAR 7 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3356

CERTIFICATE OF DEATH

103343

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 47 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				d. STREET ADDRESS Route 1			
3. NAME OF DECEASED (Type or print) Ruth				First	Middle	Last	4. DATE OF DEATH Repp
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1894		9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Indian Springs Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Forsythe				14. MOTHER'S MAIDEN NAME Mary Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Russell Repp		Address Clearspring, Md. R1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 225X Myeloma of Spinal Cord. INTERVAL BETWEEN ONSET AND DEATH 3 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 20, 1956, to Mar 8, 1956, that I last saw the deceased alive on Mar 8, 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE David R. Brewer M.D. ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 3/9/56 PHYSICIAN'S NAME (Type) David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-11-56		22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls		22d. LOCATION (City, town, or county) Western Pike Hagerstown Rural (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Rowland widow of deceased Adrian H. Rowland				24a. REC'D BY REGISTRAR Date Mar 12 1956 24b. REGISTRAR'S SIGNATURE David H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

MAR 14 1956

REGELIV ED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03344 Reg. Dist. No. 3023	
3387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring			c. LENGTH OF STAY IN lb 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) South Martin Street					d. STREET ADDRESS South Martin Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADRIAN		First MIDDLE HUYETT		LAST ROWLAND		4. DATE OF DEATH March 19 56					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1906		9. AGE (in years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 5 Days 22 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director			10b. KIND OF BUSINESS OR INDUSTRY own Business			11. BIRTHPLACE (State or foreign country) Rowland's Mill, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Percy Rowland					14. MOTHER'S MAIDEN NAME Margaret Huyett						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Margaret Rowland			Address Clearspring, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Gun Shot wound thru skull											
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 10 AM Mar. 3 1956			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with revolver (.38)								
20c. TIME OF INJURY Hour AM Mar. 3 1956			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) Clearspring, Wash Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <i>S. Robert Wells</i>										DATE SIGNED March 6 1956	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/1956		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			22d. LOCATION (City, town, or county) Hagerstown, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles M. Rogers</i> ADDRESS Hagerstown, Maryland										24a. REC'D BY REGISTRAR DATE <i>March 6-56</i>	
										24b. REGISTRAR'S SIGNATURE <i>Joseph W. Murray</i>	

MANITOBA STATE POLICE - WINNIPEG 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03345

3388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arthur Thomas Samuels		First Arthur	Middle Thomas
4. DATE OF DEATH March 3 1956	Last Samuels	Month March	Day 3
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH August 17, 1891
8. AGED (In years last birthday) 64 yrs.		9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas W. Samuels		14. MOTHER'S MAIDEN NAME Anna M. Hoover	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-09-7858	
17. INFORMANT Mrs. Anita V. Rice		Address R # 2 -Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Carbon Monoxide gas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Had connected exhaust pipe with hose thru trunk into interior of car	
20c. TIME OF INJURY Month, Day, Year Hour 10:00 p.m. Mar 3 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) garage
		20f. (City or town) Rural Hagerstown, Wash., Md	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22. ACTUAL SIGNATURE S. Robert Wells	DATE SIGNED March 6 1956		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-7-56	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown, Md.		ADDRESS Attn. G. Hunt VPres.	24a. REC'D BY REGISTRAR DATE Mar 6 1956
		24b. REGISTRAR'S SIGNATURE Chas. T. Powers	

WISCONSIN STATE EXAMINATION CERTIFICATE OF DEATH

BUREAU Y. S.

MAR 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03346

Reg. Dist. No.

302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro, Maryland		d. STREET ADDRESS -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 81 Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Luther Schildknecht		First	Middle	Last	4. DATE OF DEATH Month March	Day 4	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 1, 1871	9. AGE (in years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Abraham Schildknecht		14. MOTHER'S MAIDEN NAME Esther Flock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT MRS STEWES D. KELLEY Boonsboro MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0		Fractured Lt. Femur				INTERVAL BETWEEN ONSET AND DEATH 11 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Hypertensive arteriosclerotic heart disease					
DUE TO (c)		Hypostatic pneumonia					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME					
20c. TIME OF INJURY Month, Day, Year Hour XX:XX p. m. Feb. 21 1956		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Boonsboro Wash Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>S. Robert Wells</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 5 '56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 7 '56		22c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Moslem		22d. LOCATION (City, town, or county) (State) Boonsboro, Wash Md.	
23. FUNERAL DIRECTOR'S SIGNATURE BAST FUNERAL HOME		ADDRESS Boonsboro, Md.		24a. REC'D BY REGISTRAR Mar. 8. 1956		24b. REGISTRAR'S SIGNATURE J. Ernest Bowers	

DEATH CERTIFICATE **DEATH CERTIFICATE**

BUREAU V. S.

MAR 12 1956

REGELVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03347

3358

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 43 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 816 The Terrace			d. STREET ADDRESS 816 The Terrace-		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EMMA	First LEAH	Middle SCHINDEL	Last	4. DATE OF DEATH March 25	Month Day Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert J. Eyrely			14. MOTHER'S MAIDEN NAME Susan C. Mittag		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Catherine Poole Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio-vascular disease			INTERVAL BETWEEN ONSET AND DEATH 1½ yrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diverticulitis			2 mo.		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1st, 1954 , to Mar. 25, 1956 , that I last saw the deceased alive on Mar. 25th, 1956 , and that death occurred at 11:30 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) M.D. 138 W. Wash. St., Hag. Md.					
DATE SIGNED 3/26/56					
ACTUAL SIGNATURE Ernest F. Poole, M.D.					
PHYSICIAN'S NAME (Type) Ernest F. Poole, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/1956		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Charles M. Roemer					
ADDRESS Hagerstown, Maryland					
24a. REC'D BY REGISTRAR Mar. 27, 1956					
24b. REGISTRAR'S SIGNATURE Chest Bowers					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 390514-00000 00000 00000 00000 00000

BUREAU V. S.

MAR 29 1956

REGELIV ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3399 CERTIFICATE OF DEATH

03348

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.			b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			c. LENGTH OF STAY IN 1b 2 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville			d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First Etta	Middle Ellen	Last Schroyer	4. DATE OF DEATH Month 3			Day 25	Year 1956		
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 21, 1873			9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Uriah M. Palmer			14. MOTHER'S MAIDEN NAME Mary Hessong			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none			17. INFORMANT Mrs. Milo Dusing, Boonsboro, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure												INTERVAL BETWEEN ONSET AND DEATH
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis			DUE TO Cerebral Arteriosclerosis									14 yrs.
(c) Central Hemorrhage - Arterosclerotic			DUE TO Central Hemorrhage - Arterosclerotic									14 yrs ago.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown, Md.			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 25, 1956 to May 25, 1956 , that I last saw the deceased alive on May 25, 1956 , and that death occurred at 9 A.M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE J. D. Wilson, M.D.												DATE SIGNED
PHYSICIAN'S NAME (Type) J. D. Wilson												
22a. BURIAL, CREMATION, REMOVAL (Specify) burial			22b. DATE THEREOF 3/27/1956			22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Walk U.B. Cem. Frederick Co.			22d. LOCATION (City, town, or county) Md.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.			ADDRESS			24a. REC'D BY REGISTRAR Mar. 29, 1956			24b. REGISTRAR'S SIGNATURE Robert Powers			

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

TELEGRAM

TELETYPE

TELEFAX

BUREAU V. S.

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3390

CERTIFICATE OF DEATH

Dr Dittlo

03349
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penns.		b. COUNTY Franklin		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 42 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg RFD		d. STREET ADDRESS The Pines		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Honewood Church Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ELLA	Middle B	Last SCHUCHMAN	4. DATE OF DEATH	Month March	Day 15	Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Oct 30 1866	9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cashtown Pa.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Saylor				14. MOTHER'S MAIDEN NAME Henrietta Laufer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Records of Homewood Church Home		Address Williamsport Pa.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 yr				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Hagerstown	(State) Pa	
21. I certify that I attended the deceased from 6-1-1955 , to 3-18-1956 , that I last saw the deceased alive on 3-7-56 , 19, and that death occurred at 71 M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown								DATE SIGNED 3/16/56
ACTUAL SIGNATURE <i>J. W. Dittlo</i>	M.D. <i>Hagerstown</i>							
PHYSICIAN'S NAME (Type) Dr E.W. Dittlo Jr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/17/56	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Grove Cemetery	22d. LOCATION (City, town, or county) Chambersburg Franklin Co Pa					
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	24a. REC'D BY REGISTRAR Mar. 19, 1956					
			24b. REGISTRAR'S SIGNATURE Thas H. Bowers					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - NEVADA - SALINAS

CERTIFICATE OF DEATH

SEARCHED	INDEXED	SERIALIZED	FILED
MARCH 21, 1956			
FBI - SACRAMENTO			
RECEIVED BUREAU V. S.			
MAR 21 1956			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Poole

03350

3359

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 723 No Locust St			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHESTER		First RALSTON	Middle SEMLER	Last SEMLER	4. DATE OF DEATH March 8 1956	Month March	Day 8	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 9 1899	9. AGE (In years lost birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Air Craft		11. BIRTHPLACE (State or foreign country) Hagerstown Md.					
13. FATHER'S NAME Thomas Semler		14. MOTHER'S MAIDEN NAME Mary Cramer							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 814-09-0476		17. INFORMANT Mrs Clara Semler		Address 723 No Locust St Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO Coronary Thrombosis and									
{ (c) DUE TO Myocardial Infarction						12 hrs.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 138 W Washington St		(County) Hagerstown	(State) Md.
21. I certify that I attended the deceased from _____ 3/3, 1956, to 3/18, 1956, that I last saw the deceased alive on 3/8, 1956, and that death occurred at 11:25 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Ernest F. Poole, M.D.						ADDRESS (Street, city or town, state) Hagerstown Wash. Co Md			
PHYSICIAN'S NAME (Type) Ernest F. Poole, M.D.						DATE SIGNED 3/9/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE André K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Mer. 12 1956		24b. REGISTRAR'S SIGNATURE John H. Powers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - CHICAGO - ILLINOIS
CERTIFICATE OF DEATH

BUREAU V. S.
MAR 14 1955
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3360

CERTIFICATE OF DEATH

Dr Ditto Jr

03351
303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 28 Summer St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wsh. County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) AUTUMN		First MAY	Middle SHAMBAUGH	Lost 71	4. DATE OF DEATH March 24 1956	Month March	Day 24	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 26 1884	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Magnolia W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James H. Dyche			14. MOTHER'S MAIDEN NAME Jane Rexrode					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Shambaugh Hagerstown Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelo-nephritis rt INTERVAL BETWEEN 172X ONSET AND DEATH 3 mos								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Metastatic adeno-ca generalized abdominal 9 mos								
DUE TO (c) Adeno-ca of fundus of uterus 1 yr.								
DUE TO								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-26-56 , 1956, to 3-24 , 1956, that I last saw the deceased alive on 3-24-56 , 1956, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Dr. E. W. Ditto</i>		M.D. <i>Hagerstown</i>						
PHYSICIAN'S NAME (Type) <i>J. R. E. W. Ditto Jr.</i>		<i>Hagerstown Wash. Co. Md.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md		ADDRESS Andrew K. Coffman Hagerstown Md						
		24a. REC'D BY REGISTRAR Others 29.1956						
		24b. REGISTRAR'S SIGNATURE Robert Powers						

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3391

CERTIFICATE OF DEATH

04510

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL * HAGERSTOWN		c. LENGTH OF STAY IN 1b 90	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)	First ABRAHAM	Middle M. E.	Last SHANK
4. DATE OF DEATH	Month MARCH		Day 14
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/1869
9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. CITIZEN OF WHAT COUNTRY? U. S. A.	14. MOTHER'S MAIDEN NAME SUSAN EASTERDAY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MR. FRANK SHANK, CARLISLE, PA.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hydrocele + Hernia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB. 23 , 19 56 , to March 14 , 19 56 , that I last saw the deceased alive on March 14 , 19 56 , and that death occurred at 9 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE David R. Brewer PHYSICIAN'S NAME (Type) Dr. David R. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/17/56	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Norment	ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR May 8 1956	24b. REGISTRAR'S SIGNATURE Leroy Frickler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF NEVADA - DEPARTMENT OF MOTOR VEHICLES
CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
MAY 9 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20b Film G194 3-16-56 ans

3361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03352
2020

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	c. LENGTH OF STAY IN 1b 8 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 81 Washington County Hospital		d. STREET ADDRESS Williamsport, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Luther	Last Shank
4. DATE OF DEATH March 8	Month	Day	Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1882
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 19 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Tannery	
11. BIRTHPLACE (State or foreign country) Dry Run, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Shank		14. MOTHER'S MAIDEN NAME Susan Sheeley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 220-10-3736 Mr. Samuel Shank - Williamsport, Md.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Subdural Hemorrhage (delayed) 1 hr			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver			
DUE TO (c) Fibro-myocarditis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Hypoglycemia 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down embankment back of home	
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> 3 p.m. Mar. 7 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Williamsport, Wash. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells, M.D.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 10 '56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 11 '56	22c. NAME OF CEMETERY OR CREMATORIUM RIVERVIEW CEMETERY	22d. LOCATION (City, town, or county) Williamsport, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Leaf</i>		ADDRESS Williamsport, Md.	
24a. REC'D BY REGISTRAR <i>Mar. 11, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Frank H. Bowers</i>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NY 2

13 1958

DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03353

3362

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 518 Guilford Ave.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Emmert		First Emmert	Middle 	Last Sheely	4. DATE OF DEATH Sept. 25, 1875	Month March	Day 3	Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept., 25, 1875		9. AGE (In years less birthday) 80 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 8	Hours 	Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant		10b. KIND OF BUSINESS OR INDUSTRY Produce Business		11. BIRTHPLACE (State or foreign country) Franklin County, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Calvin Sheely					14. MOTHER'S MAIDEN NAME Susan Reiff						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-09-9890A		17. INFORMANT Mrs. Alice Sheely		Address Hagerstown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 2 mns. DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Patheric sclerotic heart disease DUE TO 20 yr. (b) (c) 											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Glaucoma - Benign prostatic hypertrophy 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County) 		(State) 	
21. I certify that I attended the deceased from Sept. 21, 1955 to Oct. 3, 1956 , that I last saw the deceased alive on Feb. 22, 1956 , and that death occurred at 10 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Ditto, M.D. ADDRESS (Street, city or town, state) 217 W. Washington St., Hagerstown, Md. DATE SIGNED 3/6/56											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/1956		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Greencastle, Pennsylvania		(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE Charles M. Ringier		ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR Mar. 7, 1956		24b. REGISTRAR'S SIGNATURE Charles H. Boever					

DEPARTMENT OF JUSTICE - ATTORNEY GENERAL'S
CERTIFICATE OF DEATH

BUREAU V. S

MAR 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03354					
D.M.E. Walk. Co. Item 20 Film G195 4-6-56 ams										Reg. Dist. No. 302					
S.Rolant 10 sells, 20, 3/22/56 CERTIFICATE OF DEATH															
1. PLACE OF DEATH o. COUNTY		Washington		3363		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		c. LENGTH OF STAY IN 1b 21 days				b. COUNTY		Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington County Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown							
3. NAME OF DECEASED (Type or print)		First DAVID		Middle MARTIN		Last SHRADER		4. DATE OF DEATH		Month March	Day 19	Year 1956			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.				
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		March 22, 1872		83 yrs.		Months 11	Days 27	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Retired Conductor				Railroad				Rockdale, Maryland				U.S.A.			
13. FATHER'S NAME								14. MOTHER'S MAIDEN NAME							
David Shrader								Rosa Bragunier							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT				Address							
no		none		Bessie Worthington				Hagerstown, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Coronary Occlusion 12 hrs					
903.0 DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)										Fracture Lower 4 weeks					
DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
		Slipped on floor while walking													
20c. TIME OF INJURY		Month 2-24-56	Day 19	Year	20d. INJURY OCCURRED	While at work <input type="checkbox"/>	Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) Hagerstown	(State) Wash. Md.				
Hour a. m.								Home							
p. m.															
21. I certify that I attended the deceased from 2-20-1956, to 3-19-1956, that I last saw the deceased alive on 3-17-1956, and that death occurred at 6th M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. E. Shadley</i> M.D. ADDRESS (Street, city or town, state) <i>Hagerstown</i> DATE SIGNED <i>3/19/56</i>															
PHYSICIAN'S NAME (Type)		<i>D. E. Shadley Jr.</i>													
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		3/21/1956		22c. NAME OF CEMETERY OR CREMATORIUM		Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State)			
												Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS <i>Champlin Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Meza, 21, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Phast. Boever</i>	
Hagerstown, Maryland															

BUREAU V. S

MAR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Ditto

03355

3364

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 213 East Washington Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle JANE	Last SOUTH	4. DATE OF DEATH March 8	Month March	Day 8	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 8, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 69	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) near Greencastle Pa		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John L. Rhodes				14. MOTHER'S MAIDEN NAME Mary Elizabeth Gossard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William Edgar South		Address 213 E. Wash St Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive vascular disease DUE TO arterioclerotic heart disease (c) Diabetes mellitus DUE TO Bilateral cataracts							
INTERVAL BETWEEN ONSET AND DEATH 72 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Aug 25, 1952 , to Mar 8, 1956 , that I last saw the deceased alive on Mar 8, 1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Ditto III M.D. ADDRESS (Street, city or town, state) 217 W. Washington St., Hagerstown, Md. DATE SIGNED 3/9/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				ADDRESS 24a. REC'D BY REGISTRAR Mar 12, 1956 24b. REGISTRAR'S SIGNATURE Thelma Boerner			

BUREAU V. S.

MAR 14 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3392 CERTIFICATE OF DEATH

03356
201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Garrott's Mills		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Garrott's Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Charles	Middle William	Last Spencer	4. DATE OF DEATH Month 3 Year 28 Year 1956
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH I-31-I871	9. AGE (In years 18 ^b (Birthday) yrs.) IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY B.E.O.R.R.Co		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas A. Spencer		14. MOTHER'S MAIDEN NAME Barbara Hoffmaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nancy Belle Spencer, Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		Cause of Death Conway Declarasion INTERVAL BETWEEN ONSET AND DEATH 3wks.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/12/1949 to 3/28/1956 that I last saw the deceased alive on 3/26/1956, and that death occurred at 1:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Knoxville, Tennessee — 3/29/56			
ACTUAL SIGNATURE W.B. Carpenter					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/1956		22c. NAME OF CEMETERY OR CREMATORIAL Reformed	
22d. LOCATION (City, town, or county) Knoxville, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE G. Lee Felt		24a. REG'D BY REGISTRAR APR 4 1956 DATE Katherine Dagenhart REGISTRAR'S SIGNATURE			

DEPARTMENT OF JUSTICE - WASHINGTON, D. C.
CERTIFICATE OF DEATH

BUREAU V. S.

APR 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. W. D. Campbell

3365 CERTIFICATE OF DEATH

03356
03357

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 730 Maryland Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) ADDIE		First DOYLE	Middle SPRECHER
4. DATE OF DEATH March 4,	Month 4,	Day 19	Year 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) St. James, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Herbert		14. MOTHER'S MAIDEN NAME Urilla Wilhide	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. George Watts - 730 Maryland Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m. 19		20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 8, 1956 , to Mar 4, 1956 , that I last saw the deceased alive on Mar 4, 1956 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 145 N Washington	
ACTUAL SIGNATURE W. D. Campbell		DATE SIGNED Mar 4/56	
PHYSICIAN'S NAME (Type) Andrew K. Coffman-Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-56	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE Mar. 8, 1956	
		24b. REGISTRAR'S SIGNATURE W. D. Campbell	

ST. JEROME LAKE - WASHINGTON STATE OWNERSHIP

MAR 12 1956

RECEIVE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3366 CERTIFICATE OF DEATH

03358

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 229 S. Potomac St.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
				SWOPE	March	23,		19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1956	9. AGE (In years lost birthday) yrs. 3	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 3	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Leon R. Swope				14. MOTHER'S MAIDEN NAME Delores L. Stickell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mr. Leon Swope - 229 S. Potomac St.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Hagerstown, Md. (State)					
21. I certify that I attended the deceased from 22 Mar 1956 , to 22 Mar 1956 , that I last saw the deceased alive on 22 Mar 1956 , and that death occurred at 9:20 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE E. H. Hoach / 2/2 PHYSICIAN'S NAME (Type) Dr. E. H. Hoach / 2/2										ADDRESS (Street, city or town, state) 115 E. W. Wash. St	DATE SIGNED 3/22
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-23-56	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Md.	(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		ADDRESS 2081221220		24a. REC'D BY REGISTRAR Mar. 26, 1956	24b. REGISTRAR'S SIGNATURE Chas H. Boowers						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03359

3367

CERTIFICATE OF DEATH

Dr Bell

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 700 Marshall St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELLA	Middle ROSE	Last TALBOTT	4. DATE OF DEATH	Month March	Day 29	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH August 6 1882	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Martinsburg W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William McSherry		14. MOTHER'S MAIDEN NAME No Record					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles D. Talbott 700 Marshall St		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 1 year	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholelithiasis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to March 29, 1956 , that I last saw the deceased alive on March 28, 1956 , and that death occurred at 8:30A M , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. A. Bell</i>		ADDRESS (Street, city or town, state) 119 North Potomac St. DATE SIGNED 3-30-56					
PHYSICIAN'S NAME (Type) R. A. Bell		Hagerstown, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS Andrew K. Coffman Hagerstown Md. 24a. REG'D BY REGISTRAR Apr. 2, 1956 24b. REGISTRAR'S SIGNATURE G. Heath Boowers					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - JOURNAL OF DEATH

CERTIFICATE OF DEATH

REGISTRATION NO.

NAME

NAME

DEATH DATE

AGE
SEX

CAUSE OF DEATH

DEATH CERTIFICATION

BUREAU V. S.

APR 4 1956

RECEIVED

3393

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH: COUNTY Wash., MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place) TOWN Hagerstown Rural 5 months		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. Va. COUNTY Morgan CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berkeley Springs w.m. STREET ADDRESS (If rural give location) 85x-3	
3. NAME OF DECEASED: (First) Bessie (Middle) (Last) Unger (Type or Print)		4. DATE OF DEATH: Mar. 6. 1956	
5. SEX: F.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 5/1/87
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Morgan & son USA
13. FATHER'S NAME: Adam Bohrer		14. MOTHER'S MAIDEN NAME: Lulu	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.: None	17. INFORMANT & ADDRESS:
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X Immediate cause (a) Acute Cardiac Failure Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Due to Cerebral Hemorrhage (c)			
Interval Between Onset And Death 4 days. 5 months			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) (Year) (Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?
22. I hereby certify that I attended the deceased from Sept. 6, 1955, to Mar. 6., 1956, that I last saw the deceased alive on Mar. 5, 1956, and that death occurred at 2.20 P.M. from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED David J. Brewer M.D. Clear Spring Md 3/6/56			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF Mar. 9, 1956	NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery	LOCATION (City, town, or county) (State) Near Berkeley Springs W.Va.
DATE KEPT BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Jeff Miller	24. FUNERAL DIRECTOR ADDRESS 645	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3368 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03361

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
				a. STATE Maryland	b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hagerstown				Myersville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
Washington County Hospital				Rural # 2	
e. IS RESIDENCE ON A FARM?					
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Lee	Middle Floyd	Last Warrenfeltz	4. DATE OF DEATH Month March Day 22 Year 1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 19 yrs.
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 16, 1937	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Factory Worker		Ribbon Factory		Maryland	
12. CITIZEN OF WHAT COUNTRY?					
USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Paul W. Warrenfeltz		Dorothea Stottlemeyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		none		Address Paul W. Warrenfeltz - Myersville, Md. # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Concussion		INTERVAL BETWEEN ONSET AND DEATH 7 days	
823X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
None					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
		Driver of auto that hit tree			
20c. TIME OF INJURY Hour 4:15 p.m. Mar. 15 1956		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Highway Rural - #17 Wolfsville, Fred. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE		<i>S. Robert Wells, M.D.</i>		DATE SIGNED March 22, 1956	
EXAMINER'S NAME (Type)		S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State) Burial Mar. 25, 1956 St. Mark's Luth. Wolfsville, Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Chas H. Boowers</i>
<i>Paul F. Bittle</i>		Myersville, Md.	Mar. 24, 1956		

WEDNESDAY, DECEMBER 2, 1964
THE NEW YORK TIMES

BUREAU V. S.

1956 27 VIII

LEGEND

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03362

3369 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL INSTITUTION OR STREET ADDRESS	WASHINGTON MARYLAND HAGERSTOWN WASHINGTON COUNTY HOSPITAL	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	MARYLAND COUNTY WASHINGTON HAGERSTOWN (If rural give location) I490 PENNSYLVANIA AVE.
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) MARY E. WELLER		(Month) 3 (Day) 18 (Year) 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH OCT. 13, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ADAM WELLER		14. MOTHER'S MAIDEN NAME MARTHA SHANK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT & ADDRESS MRS. ALICE HART, BIG POOL, MD.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443X IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE WITH RIGHT HEMIPLEGIA INTERVAL BETWEEN ONSET AND DEATH 10 DAYS			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) HYPERTENSIVE ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE UNKNOWN			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. NONE			
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from SEPT. 20, 1951, to MARCH 18, 1956, that I last saw the deceased alive on MARCH 18, 1956, and that death occurred at 11-15 PM, from the causes and on the date stated above. SIGNATURE: <i>Robert Cohen</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 3/21/56	NAME OF CEMETERY OR CREMATORIUM ST. PETERS LUTHERN CEM.
24. REC'D BY REGISTRAR Mar. 23, 1956		REGISTRAR'S SIGNATURE <i>Joseph Bowers</i>	LOCATION (City, town, or county) CLEAR SPRING, MD.
25. FUNERAL DIRECTOR'S SIGNATURE John J. Clark		ADDRESS PUBLI-FAIR FUNERAL HOME CLEAR SPRING	

RECEIVED
BY THE TREASURER OF THE STATE OF CALIFORNIA

CERTIFICATE OF DEATH - 4386

DEATH CERTIFICATE

NAME RECEIVED IN OFFICE OF THE TREASURER

JOHN C. COOPER

DECEASED ON APRIL 1, 1956

AGE 65 YEARS

SEX MALE

RACE WHITE

RELIGION PROTESTANT

EDUCATION GRAVES

EMPLOYMENT FARMER

ADDRESS 1000 S. 10TH ST., BAKERSFIELD, CALIF.

CITY BAKERSFIELD

STATE CALIFORNIA

ZIP CODE 93301

PHONE NUMBER 555-1234

TELEGRAMS TO JOHN COOPER

TELEGRAMS FROM JOHN COOPER

BUREAU V. 2

MAR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3370 CERTIFICATE OF DEATH

03363

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Hagerstown 70 years.		d. STATE Maryland		b. COUNTY Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		793 Hamilton Blvd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown		
3. NAME OF DECEASED (Type or print)		First Caroline	Middle Elizabeth	Last Whitmore	4. DATE OF DEATH	Month March	Day 1	Year 19 56
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	August 2, 1865	Months Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done despite loss of working ability, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House Wife		Own Home		St. James Md.		U. S. A.		
13. FATHER'S NAME John Rowe				14. MOTHER'S MAIDEN NAME Lavina Gaylor				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		---		Earl Whitmore		Funkstown Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 422.1 6 years								
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
None.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____		July 8, 1950, to Mar. 1, 1956, that I last saw the deceased alive on February 26, 1956, and that death occurred at 1:30A.M., from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>R. A. Bell</i>		ADDRESS (Street, city or town, state) Hagerstown, Maryland. DATE SIGNED Mar. 2, 1956						
PHYSICIAN'S NAME (Type) R. A. Bell		119 North Potomac Street.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hag. Md.		24a. REC'D BY REGISTRAR DATE Mar. 5, 1956		24b. REGISTRAR'S SIGNATURE <i>Scott F. Minnich</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03364

3394

CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Byrons Tannery		e. STREET ADDRESS #2 S. Vermont Street	
3. NAME OF DECEASED (Type or print) First James Middle Frank Last Winters		4. DATE OF DEATH Month March Day 26 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31 1891
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 7 Days 23 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finisher Tannery		10b. KIND OF BUSINESS OR INDUSTRY Tannery	
11. BIRTHPLACE (State or foreign country) Mercersburg Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Finley Winters		14. MOTHER'S MAIDEN NAME Mary Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-6342	
17. INFORMANT Mrs. Lida Winters #2 S Vermont St.		Address Williamsport Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSIO			
INTERVAL BETWEEN ONSET AND DEATH Immediate			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTEROSCLEROTIC HEART DISEASE			
DUE TO 10 years.			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial asthma.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5, 1953, to 26 March 1956, that I last saw the deceased alive on 24 March 1956, and that death occurred at 8:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE PAUL HAAK, M.D.		ADDRESS (Street, city or town, state) Williamsport, Md. DATE SIGNED 21 March 1956	
PHYSICIAN'S NAME (Type) PAUL HAAK, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 28-56	
22c. NAME OF CEMETERY OR CREMATOR Y Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert A. Leal Williamsport, Md.		24a. REC'D BY REGISTRAR March 28-56	
ADDRESS		24b. REGISTRAR'S SIGNATURE E. Lee McElroy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in ink, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DEATH CERTIFICATE

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BUREAU V. S.

APR 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03365

Dr. E.W. Ditto, III 3395 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hagerstown R#3		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cool Hollow Road				d. STREET ADDRESS Cool Hollow Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHESTER	Middle ERVIN	Last WOLFE	4. DATE OF DEATH March 5 1956	Month March	Day 5	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 35, 1893	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Wolfe		14. MOTHER'S MAIDEN NAME Emma Schildknecht					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 314-16-0466		17. INFORMANT rs. Eva M. Wolfe-Hagerstown R#3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		<i>Cerebral Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH 48 hr			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<i>Arterio sclerotic heart disease</i>		(c) 15 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-5-56 , to 7-5-56 , that I last saw the deceased alive on 7-1-56 , and that death occurred at 90 M , from the causes and on the date stated above. ACTUAL SIGNATURE E.W. Wolfe M.D.		ADDRESS (Street, city or town, state) Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffren-Hagerstown, Maryland		ADDRESS Andrew K. Coffren-Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE March 8-1956		24b. REGISTRAR'S SIGNATURE John B. Bart	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - SECTION ONE

3302 CERTIFICATE OF DEATH

Date of Death

1956

APR 9 1956

BURLAU V. S.

REVIEWED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03365

3371

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.	
c. LENGTH OF STAY IN 1b week		d. STREET ADDRESS 72 Madison Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington county Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle ALFRED	Last WOLFF
4. DATE OF DEATH	Month March	Day 5	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 25 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Franklin Co., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wolff		14. MOTHER'S MAIDEN NAME Matilda C. Wolff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Leslie V. Wolff		Address 72 Madison Ave. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Cardiovascular Collapse INTERVAL BETWEEN ONSET AND DEATH min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis. hrs & min.			
DUE TO (c) gen. arteriosclerosis yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1955 to present, that I last saw the deceased alive on 3-9-56, 19, and that death occurred at 4:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis George Graff, M.D.		ADDRESS (Street, city or town, state) 119 E. Antietam St.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Louis George Graff, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
		22b. DATE THEREOF March 8-56	
		22c. NAME OF CEMETERY OR CREMATORIUM Broadfording Cemetery	
		22d. LOCATION (City, town, or county) Broadfording (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith Leaf		24a. REC'D BY REGISTRAR ADDRESS 7 Church St Williamsport Apr. 8, 1956	
		24b. REGISTRAR'S SIGNATURE Chester Boowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 12 1956

MAP 4-1
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04521

Reg. Dist. No. 303

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Rural - Dam # 4		10 min		Hagerstown		148 Ray Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		None		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles	Middle Downs	Last Wolford	4. DATE OF DEATH	Month Mar.	Day 28 Year 56
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days Hours Min.
Male		White		June 27, 1913	42 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Police - City		City Police		Hagerstown, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Downs Wolford				Catherine E. Johnston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes		244-09-6887		Peggy I. Wolford - 140 Ray St - Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Gun Shot wound thru skull DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
Shot self with .32 calibre		while sitting in car					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7:15 AM Mar. 28 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Automobile		20f. (City or town) Rural-Dam # 4 Wash. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar. 28 '56	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/56		22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown Md.		ADDRESS Wm. B. Head & Sons		24a. ICD BY REGISTRAR Died 3/28/56		24b. REGISTRAR'S SIGNATURE Joseph W. Murray	

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FBI - WASHINGTON, D.C.
APR 5 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G195 4-17-56 et

Dr. Ditto

3372

CERTIFICATE OF DEATH

Reg. Dist. No.

03367
303

1. PLACE OF DEATH o. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland Washington			
				b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
03 Hagerstown		1½ yrs.		Clear Spring					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS					
90 Martin Manor Nursing Home				Main St.					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
MARY		MATILDA		YEAKLE	March	27,		19 56	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 19 th 24, 1889	66 yrs.	Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own Home		nr. Welsh Run, Pa.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Henry A. Seibert		Cava Seiss							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Mrs. Percy Andrews-Herndon, Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Aspergillus, generalized Cerebral thrombosis					5 yrs.		
332X		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)							
{		DUE TO							
{		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		① Paralysis of left arm ② other toxic pneumonia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19									
21. I certify that I attended the deceased from <u>Mar. 10</u> , 1956, to <u>Mar. 27</u> , 1956, that I last saw the deceased alive on <u>Mar. 26</u> , 1956, and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.							ADDRESS (Street, city or town, state)	DATE SIGNED	
ACTUAL SIGNATURE		<u>Edward W. Ditto</u>					M.D.	<u>217 W. Washington St., Hagerstown, Md.</u>	<u>3/27/56</u>
PHYSICIAN'S NAME (Type)		Edward W. Ditto M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIY		22d. LOCATION (City, town, or county)		(State)	
Burial		3-30-56		St. Paul's Cemetery		nr. Clear Springs, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS							
<u>Andrew K. Coffman-Hagerstown, Md.</u>		<u>Mar. 30, 1956</u> <u>Blair Bowers</u>							
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							

BUREAU V.

APR 3 1956

APR 3 1971